CRITICAL ACCESS HOSPITALS

A collection of nine
Critical Access Hospital community stories
and two network stories

September, 2002

This publication was made possible through the support of a FLEX grant from the Federal Office of Rural Health Policy, Health Resources and Services Administration.

Special thanks to our reporter Dave Howe (Lincoln, Nebraska) and the hospitals who shared their stories with us and with our readers.

These stories can also be found on the following Web sites:

1. Nebraska Health and Human Services: http://www.hhs.state.ne.us

2. Nebraska Hospital Association: http://www.nhanet.org

3. Nebraska Rural Health Association: http://www.nebraskaruralhealth.org

We also want to thank our many stakeholders who helped make the Nebraska Story a wonderful reality. And most of all we want to thank the Nebraska rural communities who embraced this new hospital model in order to improve access to care for their residents.

The Nebraska Office of Rural Health

Published September, 2002

Nebraska Department of Health and Human Services
Office of Rural Health
P.O. Box 95044
Lincoln, NE 68509-5044
(402) 471-2337

Hospitals:

Geneva - Fillmore County Hospital

Kimball - Kimball County Hospital

Henderson - Henderson Health Care Services

Fairbury - Jefferson Commuity Health Center

West Point - St. Francis Memorial Hospital

Ainsworth - Brown County Hospital

Callaway - Callaway District Hospital

Albion - Boone County Health Center

Osmond - Osmond General Hospital

Networks:

Lincoln: BryanLGH Hospital Network

Kearney: Good Samaritan Hospital Network

Eligible and Certified CAH Hospitals Map
View Map at: http://www.hhs.state.ne.us/other/CAHhospitals.jpg

CAH-Network Map
View Map at: http://www.hhs.state.ne.us/other/CAHnetwork.jpg

Overview

The U.S. Congress made an important decision to invest significantly in America's rural hospitals when it created the Rural Hospital Flexibility Program (Flex Program) as part of the Balanced Budget Act (BBA) of 1997. The Critical Access Hospital (CAH) Program is one of the central features of the Flex Program. Its intent is to allow rural communities to preserve access to primary care and emergency services, provide healthcare services that meet community needs, and help assure financial viability of program participants through improved reimbursement and different operating requirements.

The Flex Program was made available to any state, which chose to develop a rural health care plan that provides for the creation of one or more rural healthcare networks, promotes regionalization of rural health services, and improves access to hospital and health services for rural residents. In 1998, the Nebraska Office of Rural Health and the Nebraska Hospital Association co-authored the original state plan to implement the Medicare Rural Hospital Flexibility Program in Nebraska. The Federal Government, in early 1999, approved Nebraska's Plan.

Today, the Nebraska CAH program continues to be administered by the Nebraska Office of Rural Health, in very close collaboration with the Nebraska Hospital Association. Nebraska has been extremely active in establishing and implementing the Nebraska Critical Access Hospital Program over the past four and one-half years. Nebraska is recognized around the country as having one of the more innovative and successful Critical Access Hospital programs. The state's 59 CAH-certified facilities by the end of 2002 are a reflection of that program's high quality.

Conversion to CAH status has helped rural Nebraska hospitals improve financial performance, address quality issues, and network with other hospitals. It has also allowed our state to make progress on improvements in the rural EMS system. In addition, preliminary results show participating hospitals in Nebraska are enjoying better cash flows as a result of joining the program. To the extent that these financial results are attributable to program participation, the program may cautiously be credited with stabilizing a number of small rural Nebraska hospitals.

The goals of the Flex grant program are to:

- Establish statewide rural health plans;
- Assist hospitals interested in being designated and certified as CAHs;
- Develop and strengthen hospital networks;
- Improve quality of care; and
- Improve emergency medical services (EMS) in rural communities.

Beyond the cost-based reimbursement aspect of the CAH program, administered by Medicare, the second portion of the Flex Program is a 4-year, $25 million annual grant program available to the states.

The Nebraska CAH Program staff has written four successful Flex Program grants for a total of $2.87 million to assist in the development of the program in our state.

The Flex grant portion of the program expires at the end of federal fiscal year 2002-2003, unless renewed by Congress. Reauthorization and continuing implementation of the Flex Program represent an opportunity to further assist states, rural hospitals, and rural communities to continue to develop innovative, collaborative strategies and technical assistance programs for stabilizing and strengthening rural hospitals and community health systems. This reauthorization is very important to rural health care in the State of Nebraska.

There is no doubt that the Rural Hospital Flexibility Program has had far-reaching effects on rural health care in the United States. There is likewise little doubt that significant changes in the Nebraska rural healthcare landscape are attributable to this initiative. We are very pleased to be able to share several stories that illustrate the Flex Program's impact on Nebraska communities and, ultimately, access to health care for many rural Nebraskans.

CRITICAL ACCESS HOSPITALS

A NEBRASKA Story

GENEVA: Fillmore County Hospital

BY DAVE HOWE

The prognosis for the 25-bed Fillmore County Hospital's future viability wasn't very favorable several years ago. The building needed roof repairs and brickwork. Diagnostic equipment was due for replacement. Computer software needed to be updated.

Conditions such as those were complicating the hospital's recruitment and retention of healthcare givers and leading to outmigration of patients for health services.

Yet this hospital plays a crucial healthcare and economic role in this rural area.

Like many other rural Nebraska hospitals, this one serves a community whose economic base is primarily agriculture and retirees. Located in Geneva, near the geographic center of Fillmore County, the hospital serves a population of 9,000 within a 30-mile radius. One in every five residents is 65 or older.

The hospital's emergency room and staff receive patients transported by volunteer EMS squads at five towns in the county.

Not surprisingly, two of every three patients here are on Medicare. Another one in 10 is on Medicaid, says Hospital Administrator Larry Eichelberger. The shortfalls between cost of serving those patients and the reimbursement schedules authorized under Medicare and Medicaid were depleting Fillmore County Hospital's reserve fund, according to Eichelberger.

FILLMORE COUNTY HOSPITAL

- Located in Geneva, population 2,300, in center of Fillmore County in southeast Nebraska
- Serves 30-mile-radius area
- Area population is about 9,000, 20% of whom are 65 or older
- Economy is Primarily agriculture and retirees
- Distance to next closest hospital is 20 miles

FOR FURTHER INFORMATION, CONTACT:

Larry Eichelberger (402) 759-3167
Dave Palm (402) 471-0146
John Roberts (402) 421-2356
Dennis Berens (402) 471-0142

New Life

That was before the hospital and other rural hospitals like it began to find new life through the Critical Access Hospital (CAH) program created by legislation enacted by Congress in 1997. A rural hospital's eligibility for conversion to a CAH includes meeting at least one of several criteria, which relate to a shortage of existing medical services and age and poverty level of the population served by the hospital. Once converted to a CAH, the hospital can receive cost-based reimbursement for medical services rendered to Medicare patients.

As a CAH, Fillmore County Hospital is not only able to keep its doors open but is able to upgrade its healthcare services. These services, which would not otherwise be available locally, are especially important to this rural community's elderly members, many of whom lack convenient transportation. Local healthcare services also enhance local doctors' ability to care for their patients.

"One of our greatest concerns was that we wouldn't be able to attract new physicians and retain employees. Those are two of the big things," Eichelberger says. Conversion to a CAH makes it possible to pay competitive wages to its personnel and maintain updated equipment and facilities. Health professionals don't want to come to a hospital that doesn't have good equipment, he adds.

Long-term care is not part of the CAH program. But without that program to help keep this hospital in business, its 20-bed long-term care wing would not be here, either, Eichelberger points out.

The CAH program's payoff goes beyond helping this hospital continue to provide better healthcare access to the community. It's also an economic boon to the community. With a staff of 112 and a payroll of $3.1 million, Fillmore County Hospital and its clinic are the largest employer in the county.

"Needless to say, small towns are having to struggle," Eichelberger says. Pulling a hospital out of a town can be an even greater economic blow to a community than the loss of a school, he adds. It's not only the hospital employees and their family members who bolster the community's economic base; it's the boost in retail trade from patients and their families that healthcare services bring to town. When they come to see the doctor, they may also visit the grocery store, the hardware store and the pharmacy, for example, Eichelberger notes.

Another important part of the rural hospital solution is 1999 federal legislation that created the Medicare Rural Hospital Flexibility Grant Program. It provides federal funding to the states. The states, in turn, use that funding to provide technical assistance to help cash-strapped rural hospitals complete the necessary feasibility studies, planning and other processes leading to CHA designation and the transition that follows.

Operating on Flexibility Grant funds, the Office of Rural Health in Nebraska's Health and Human Services System and the Nebraska Hospital Association provided Fillmore County Hospital the help it needed for conversion to a CAH in October 1999. It was the first of Nebraska's 58 current CAHs to become a CAH.

"The hospital governing board and the physicians were involved from the very first. Because we are county-owned, the county supervisors were also involved. The hospital auxiliary was involved, too," Eichelberger says.

Critical Help

"The assistance we received was very critical for us," Eichelberger says. "We had made the determination that we were going to CAH early-on. And, because we were in fact one of the first, there was no experience or history to lean on. The rules and regulations of CAH came to us through a contract with John Roberts and the (Hospital) association. In addition, Denny Berens (Office of Rural Health in Health and Human Services) and Dave Palm (Office of Public Health) helped us educate the governing board when we first began talking about CAH."

The State of Nebraska has also authorized cost-based reimbursement for Medicaid patients at Nebraska CAHs. Ten percent of patients seeking healthcare at Fillmore County Hospital are on Medicaid. Three of every four patients here are on either Medicare or Medicaid. The CAH program, the Rural Hospital Flexibility Grant Program and state legislative and administrative support are all playing a vital role in maintaining quality healthcare in this rural area.

Where would this hospital be without these programs? "I don't even want to think about it," answers Hospital Administrator Eichelberger. They have enabled the hospital to complete building repairs; install a new CT scanner and remodel the room that houses it; purchase a diagnostics lab; upgrade the hospital's computer system; add equipment to a fitness center, which is part of the hospital; upgrade fiber optic scopes for diagnostic purposes; and install a new anesthesia machine. All of these changes are for the benefit of patients, especially Medicare and Medicaid patients.

Through Heartland Health Alliance in Lincoln, Lincoln BryanLGH and the Nebraska Heart Institute, a number of specialty doctors come out to Fillmore County Hospital to hold clinics. The clinics include specialists for cardiac care; MRI scanning (a mobile unit from Shared Medical Services); orthopedics; ear, nose and throat; ophthalmology; gastroenterology; dermatology; and urology.

The CAH program requires that a CAH be in a network with a major hospital to which patients are transferred when they need care beyond what the CAH is capable of offering. St. Elizabeth Community Health Center in Lincoln is Fillmore County's network hospital.

"Hospitalists"

Fillmore County Hospital Chief of Staff Dr. Jason Bespalec says one of the ways St. Elizabeth helps CAHs is having "hospitalists" on its staff. These physicians, who practice only at St. Elizabeth, are assigned to patients transferred there from a CAH. A hospitalist and CAH doctor work closely together, with the hospitalist facilitating specialists' acceptance of CAH patients coming to the network hospital. Hospitalists and CAH physicians maintain a direct link, sharing patient information and providing strong continuity of care between the CAH and the network hospital.

From a physician's viewpoint, one beneficial change in the CAH program is a modification of the "96-hour rule," which limited a patient stay to 96 hours in a CAH hospital, says Dr. Bespalec. Now, the 96-hour limit applies to the average length of stay for all patients rather than to each patient stay.

Physician peer reviews and patient satisfaction surveys help Fillmore County Hospital and its physicians monitor and maintain high quality healthcare. The hospital's physicians belong to SERPA (Southeast Rural Physicians Alliance), which conducts physician peer reviews of doctors belonging to SERPA and will also do reviews of physicians anywhere in the state.

SERPA and a rural hospital organization called the Blue River Valley Network, an organization of 15 rural southeast hospitals—all but one a CAH—comprise the Rural Comprehensive Care Network (RCCN) that conducts patient satisfaction surveys of the 15 hospitals in the Blue River Valley Network.

Eichelberger now views Fillmore County Hospital's future with optimism. Among goals for the future: Upgrading the emergency room and giving a "facelift" to the hospital's surgical facilities.

A NEBRASKA Story

KIMBALL: Kimball County Hospital

KIMBALL COUNTY HOSPITAL

- Located in southern panhandle of Nebraska
- Serves a population of about 9,000, 20% of whom are 65 or older
- Economy is primarily ranching and farming
- Distance to next closest hospital is **50 miles**
- Patient Census Profile in 2001 was 48% uninsured, 19% Medicare, 7% Medicaid

FOR FURTHER INFORMATION, CONTACT:

Kim Woods, (308) 235-1952
Jim McHugh (308) 630-1468
Dave Palm (402) 471-0146

BY DAVE HOWE

Imagine seeking healthcare services at a hospital that has seen little of the remodeler's saw and hammer since it was built a half century ago. Round out the scene with a clinic equipped with exam tables that have ripped tops and equipment reminiscent of medical technology when Harry S. Truman was President.

That's a picture of what Kimball, Nebr., residents saw several years ago, when they came to Kimball County Hospital and Clinic. Many of the patients from this sparsely populated Nebraska Panhandle community chose to go elsewhere for medical services if they could tolerate the hardships and inconvenience of travel to more distant facilities. The next closest hospital is Regional West Medical Center in Scottsbluff, Nebr., an hour's drive away.

Languishing

Meanwhile, Kimball County Hospital languished. "We had months when we had zero patients for days or weeks on end," says hospital CEO Kim Woods. "If we had one or two patients per day, we were thrilled," she says, explaining the consequences of long-neglected updating of the hospital building, clinic and its equipment.

No more!

A 12,000-square-foot remodeling project and an equally large addition to this 52-year-old structure are nearing completion. The health clinic, formerly in a downtown location, will soon be moved into the new space with all new equipment and will also house inpatient and outpatient services such as rehab and physical therapy.

What brought about this badly needed transformation of the 20-bed Kimball County Hospital that serves about 6,000 people in the southern panhandle of Nebraska, along with eastern Wyoming and northern Colorado?

In a word: Cash. More precisely, it's cash flow, leveraged by conversion to a critical access hospital (CAH) in 1999, just 2 years after Congress enacted the CAH program.

Percentage of the hospital's patients on Medicare in 2001 was 19%, with another 7 percent on Medicaid. Although only about one in four of the hospital's patients is a Medicare or Medicaid patient, the cash flow generated by cost-based reimbursement for those patients under CAH status leverages what the hospital is able to do in the way of services, equipment and staffing, according to Woods.

That cost-based reimbursement is an important catalyst to this hospital's cash flow, helping propel the hospital to a source of modern, high quality healthcare services. How that is so may be best understood by first delving a little deeper into how the region's demographics pose a challenge to maintaining a top-notch healthcare facility here:

- Farming and ranching comprise a major portion of the local economy. Woods says a significant portion of the population has an annual income below the federal poverty level.

- Forty-eight percent of the patients at the hospital last year were uninsured, according to Woods, citing the hospital's audited financial records from 2000 and 2001.The hospital receives patients transported from the "rolling community" of two nearby major highways—Interstate 80 and Highway 71—by the county-operated EMS squad, which is scheduled to become part of the hospital operation in 2 years.Many of the patients who are insured have high deductibles, which they or their employers buy, in an attempt to keep premiums affordable. Reimbursement to the hospital for those high deductible portions wind up being paid over extended periods in many cases.

Leverage

The aforementioned factors place a strain on the hospital's cash flow. However, the cost-based, timely reimbursement for Medicare and Medicaid patients, even though they are only 25 percent of the hospital's patient census, leverages cash flow.

Woods explains it this way: "Being a CAH brings more cash into our facility. When you have more cash to do things, you can then buy equipment and you can provide more services." That attracts more patients. And more patients bring more revenue, which in turn permits more investment in equipment and services, Woods explains. "It just kind of snowballs."

Now, instead of going days with no patients, this hospital averages five to seven patients a day in acute care and swing beds, with the hospital census reaching as many as 12 patients a day.

Recalling the difficult days of zero patient census several years ago, Woods says: "It's hard to have cash flow when you don't have people coming into your hospital."

Cashflow, kick-started through the CAH program, is making the difference, according to Woods. It allows the hospital to provide equipment and rooms for medical procedures that the hospital's two physicians and physician assistants would not otherwise be able to provide, she says. "We've basically replaced everything in the building. We had stuff in this hospital that I'm sure was installed when the hospital was built in 1950. You want equipment that looks nice. People equate equipment with the kind of healthcare they are going to receive."

No More Begging

Cash flow that permits better equipment and more competitive compensation helps with recruitment of health professionals. "Before, it was almost a matter of begging them (health professionals) to come," says Woods. Now, when prospective health professionals visit, she says, "they no longer have that look in their eyes, 'Oh, my gosh! You want me to come work here?'"

They and patients have the benefit of a cardiac stress-testing machine, an updated emergency room, a laproscopic endoscopy machine, a new trauma cart to handle trauma patients, updated lab equipment that includes a chemical analyzer for blood testing, a portable X-ray machine, and strength and exercise equipment for rehab patients coming to the aforementioned inpatient/outpatient hospital addition.

Kimball County Hospital's journey to where it is today began before the CAH program came along, according to Woods, who became its CEO 2 years ago. About 10 years ago, the board of directors faced a decision between making major changes or just keeping the facility open. "They knew they had to keep the hospital open. Our closest hospital is 50 miles away," Woods says. The board decided on major changes that would do more than just keep the doors open. "A lot of painful decisions had to be made."

Even if the hospital had not become a CAH, it would have remained open, according to Woods. But without becoming a CAH, she says, ". . .we would have had to ask the county to subsidize us more. We would have just been status quo (even with major changes required to stay open). We would not have been able to grow, because we didn't have any cash. We'd have just stayed alive."

The hospital board, county commissioners and hospital staff all recognized how important it is for a community such as Kimball to have a first-rate healthcare facility.

Community Boost

"You will soon see a community deteriorate, if its hospital closes," Woods says. It affects industry and businesses that come to your community, she continues. "They don't want to come into a community where, say, someone (employee) needing two stitches in his finger has to drive 50 miles to have it done. Or, what if you're a person having a heart attack and no facility is close? You're probably going to be dead by time you get to a facility an hour away."

Operating as a CAH, the hospital has gone from between 45 and 50 employees to about 90 today, creating a large favorable direct impact on the economy. Add to that the added business activity attracted to the community. "When you

bring more services to the community, you have more people coming to your community," Woods notes. While they're there, they stop at the pharmacy, discount store and the cafe. "So, that has a big impact."

Conversion to a CAH was not a hard sell in the community, according to Woods. An information program handled by the Nebraska Hospital Association placed flyers, poster boards and other written materials in the hospital and elsewhere in the community, explaining to residents what a CAH is and what being a CAH means. That's part of the technical assistance available to rural hospitals under the Federal Medicare Rural Hospital Flexibility Grant Program. Funded by that grant, the Office of Rural Health in Nebraska's Health and Human Services System (HHSS) offers technical assistance to rural hospitals to carry out financial feasibility studies, planning and other measures required of a rural hospital seeking CAH status. Rural hospitals generally lack the resources to take those steps.

"We had no opposition (to CAH conversion) from the community. When you are looking at bringing more money into the hospital so that it can offer more services and don't have to ask for more tax money, that's not a hard sell," Woods says. "Voters knew we had gone to a CAH when the vote (on the $2.3 million bond issue) came up." They approved the bond issue by a 3-to-1 margin.

Focus on Future

Operating as a CAH, Kimball County Hospital is no longer in a survival mode. It can now focus on identifying health services needed in the community and working toward meeting those needs. "CAH lets us do that," Woods says.

"We have met almost all of the goals set in 1999 (when the hospital converted to a CAH)," she continues. Next up is a 5-year strategic planning session, which involves the hospital board of trustees and hospital department heads. "It's a road map of where we think we want to go in the next 5 years," Woods says. The plan includes a schedule of what has to happen at key intervals along the way to achieving the 5-year goals.

The successes of the hospital are the best testimony to the community when it comes to proclaiming the benefits of being a CAH, Woods believes. "The biggest part is they can see how different we look. We look like a brand new hospital." They experience it in the new equipment and services they find at the hospital and clinic.

Additionally, this county hospital provides quarterly reports to the county commissioners. Those reports lay out the hospital's finances and services for the commissioners to see.

The benefits of CAH status go well beyond financial stability, Woods notes. The whole process of going to CAH status has made the hospital more professional. Before converting to a CAH, just keeping the doors open siphoned off a lot of thinking and energy.

The route to becoming a CAH includes a survey of the hospital's regulations, policies and procedures. That process can in itself be a benefit, Woods believes. When Kimball County Hospital began preparing for the survey 3 years ago, only one of the hospital's 15 department heads had been through a survey, which is conducted by personnel in HHSS. It had been more than 5 years since the last survey. In that many years, a lot of things had changed.

Higher Level

"You can read the regulations, but if you have never been through one (survey), there are a lot of questions about how it works," Woods says. As a consequence of preparing for that survey, everyone went through the policy and procedure books, which needed updating, Woods says. "We had stuff typed on pieces of paper and handwritten notes in policy books."

Now complete policy books are on the computer, which can be updated quickly. The process taught the staff how to collaborate with other departments. A lot of department heads became aware of how important it is to make sure policies make sense and are consistent. Consequently, hospital policies have been changed and updated, bringing them up to professional standards.

A CAH must be affiliated with a network hospital. Kimball County Hospital's network hospital is Regional West Medical Center in Scottsbluff. That is the hospital to which patients are transferred for care that Kimball County Hospital cannot provide.

Even before CAH status, the two hospitals had a close working relationship, according to Woods. "It was a natural facility for us to pick." Very close coordination between the two institutions and their doctors in sharing medical records and other patient information when patients are transferred to the network hospital assure an appropriate continuum of care, Woods says. It's a two-way street, with the same close sharing of patient information when patients are either discharged from the network hospital or transferred back to Kimball County Hospital.

Symbiotic Relationship

Jim McHugh, vice president of medical services at Regional West Medical Center, describes the connection between the network hospital and CAHs as a "symbiotic relationship." CAHs and the network hospital benefit from closely coordinated procedures and standards for such activities as patient transfers between the network hospital and CAHs.

McHugh goes on to point out that healthcare consumers benefit from the CAH program by being able to enter the healthcare system close to home. Close coordination of procedures and care between the CAH and its network hospital facilitates the transfer of patients to the network hospital when they require a level of healthcare not available at the CAH. However, McHugh says, that doesn't mean patient transfer options are limited to the network hospital.

Another role of the network hospital is to assist as a partner with CAHs in such matters as credential verification (information-gathering on background and qualifications) of new physicians that a CAH is considering for its staff, McHugh says.

Yet another major benefit of a CAH network is quality improvement and quality assurance, Woods says. Kimball and three other CAH hospitals (at Oshkosh, Bridgeport and Chadron) that are affiliated with Regional West Medical Center work closely with a quality improvement coordinator at Regional West. The quality improvement coordinator at Regional West Medical Center gives each of the four affiliated CAHs feedback on how quality of its care compares with that of the other three hospitals in the network and meets quarterly with the four hospitals.

For a Textbook

"That is something that you should see in a textbook," Woods says. "We were the first in the state to get ours up and going." The four hospitals, working with Regional West's quality improvement coordinator, have developed quality standards and a plan for meeting those standards.

Kimball County Hospital has also hired a quality improvement coordinator who reviews medical records to determine if care was appropriate and suggests changes that would improve quality of care.

"Quality assurance has been one of the major success pieces of the CAH program in this region," says McHugh at Regional West Medical Center.

Peer reviews of physicians and PAs are also conducted through the regional network, which is another benefit of the CAH program. "It's difficult for a small, rural hospital to do a peer review," Woods says. Through the network, peer review criteria have been set up in conjunction with Regional West Medical Center. The four hospitals in the network review each other's medical records each month. "That has worked extremely well," Woods says.

Many aspects of Kimball County Hospital now work extremely well, she says. "It was very beneficial for us to make that conversion to critical access, and that's why we did it very quickly."

CRITICAL ACCESS HOSPITALS

A NEBRASKA Story

HENDERSON: Henderson Health Care Services

HENDERSON HEALTH CARE SERVICES

- Strong Community support for Health Care Services.
- Nearly 60% of hospital patients on Medicare or Medicaid
- Hospital went from nearly forced to close its doors to building a new clinic and enhancing long-term care facilities.
- Strategic planning, long neglected, now a vibrant tool embracing proactive steps toward serving all age groups in the community.

FOR FURTHER INFORMATION, CONTACT:

Marianna Harris (402)723-4512
Dave Palm (402) 471-0146
John Roberts (402) 421-2356
Dennis Berens (402) 471-0142

BY DAVE HOWE

Small town residents are renown for spirited loyalty to their schools. But that kind of dedication doesn't end on the athletic field or in the classroom at Henderson, Nebraska, population 990.

The non-profit hospital and its related Health Care Services in this southeast Nebraska community have a major following among the 3,500 to 5,000 people living in Henderson and within a 20- to 25-mile radius of the hospital.

Many residents stand ready to rally around Henderson Health Care Services, a complex that includes a 13-acute-care-bed hospital, healthcare clinic 42-bed nursing home, 16 assisted-living units and four independent-living units. Anyone giving $100 to Henderson Health Care Services, Inc., becomes a lifetime voting member. A large number of residents make that contribution not just once but repeatedly. "We've been averaging $80,000 a year (in total annual contributions)," says Henderson Health Care Services, Inc., Board Chairman Alan Janzen. Some years, the figure is much greater than that, he adds.

Fund-raisers, including this year's "Spring Fling" that included an auction of donated items, have raised $315,000 over 3 months' time for the hospital.

Keeping Healthcare Local

"Everyone wants healthcare in Henderson," says Marianna Harris, hospital administrator at Henderson Health Care Services. "They don't want to go outside of the community for healthcare. It's a big thing to have it (locally)."

But despite the strong community support, an ailing fiscal condition was threatening this facility. Keeping the hospital updated to meet the needs of patients, many of them on Medicare for which reimbursement lagged actual cost of serving them, was creating a financial strain on the hospital. By June 1999, it looked as if the hospital wouldn't have enough money to keep going, Harris says.

Cash reserves had been depleted, says Board Chairman Janzen. The corporation's financial status "was in a pretty steep decline," he says.

The situation prompted a community meeting at which the Henderson Health Care Services board of directors explained the situation. The board and corporation members were undeterred, according to Harris. "They said they weren't closing the doors."

Commitment by the hospital's faithful kept the doors open. But that commitment received some strong medicine in the form of the Critical Access Hospital (CAH) program, a program created by legislation enacted by Congress in 1997.

A rural hospital that meets at least one of several criteria relating to health professional shortages and age and poverty level of the community served is eligible to apply for CAH status. In the Henderson case, it was the age factor (18.4% 65 or older) in York County, where the hospital is located.

CAH status qualifies the hospital to receive cost-based federal reimbursement for its Medicare patients. Additionally, the State of Nebraska authorized cost-based reimbursement for Medicaid patients at CAHs a year ago.

The Henderson hospital became a CAH on Dec. 1, 1999. Nearly half of its patients in 2001 were on Medicare; another 8% were on Medicaid. With more than half its patients on Medicare or Medicaid, cost-based reimbursement is a boon to this hospital's future.

A financial feasibility study, one of the requirements for becoming a CAH, projected that patient revenue would increase by 13.1% if the hospital operated as a CAH. The hospital did better than projected, posting a 16.4% increase in its first full year as a CAH, according to Harris.

Hospital Milestones

"Even if the CAH hadn't gone through, we would have remained open, because of community support," she says. But because it did go through, the hospital has gone from just surviving to embarking on a path leading to the following healthcare milestones benefiting people of all ages in this community:

- A 5,000-square-foot addition to the 52-year-old hospital building. Groundbreaking for the addition, which is to be the hospital's medical clinic, was held in August 2002. (Accommodating two new physicians coming to town is one of the reasons for the new clinic, Harris says. They are joining the 1½-time-physician staff and a physician's assistant at the clinic.)
- Long-range plans for a physical fitness center and heart rehab in the new clinic's basement.
- Establishment last October of the hospital's own laboratory, which includes a chemical analyzer for blood tests. Having the in-house lab in place of contracting out lab work provides a hospital revenue source as well as shorter turn-around times on lab results for patients and doctors. Any tests the hospital lab can't run are referred to the lab at Mary Lanning Hospital in Hastings.
- Initiation of the hospital's own physical therapy in place of contracting out that service.
- Planned reinstatement of OB services this summer, a step toward serving the younger sector of the population.
- EEG services provided at Henderson Health Care Services facility on an as-needed basis by Mary Lanning Hospital at Hastings.

"I don't know if it's because of more optimism or new services that we've added, but our census has increased," Harris says. "The community is using our services."

No Cash Cow

"Cost-based reimbursement isn't a cash-cow," says hospital board chairman Janzen. "But from a business standpoint, when you can improve cash flow in one area, you can build on that." That's what cost-based reimbursement of a CAH does, he adds. It leverages the income stream for improvements elsewhere in the operation, which in turn further build the business, explains Janzen, an area livestock producer.

Even as a CAH, the hospital will always confront financial challenges necessitating reliance on cash contributions from the community, Janzen says.

A community health systems study conducted 2 years ago showed that the Henderson facility was capturing about 24%, or $5.1 million to $5.4 million, of the $14 million to $15.4 million in healthcare spending in the hospital's marketing area. Keeping enough healthcare providers in the hospital to attract more of those dollars has been a significant challenge the past 15 years, Janzen says. But with the stronger financial footing afforded by the CAH program, he says, it's easier to attract those providers. "The hope is that with a larger provider base and more consistent service, we will be able to capture more of the healthcare spending."

Between the CAH and strong community support, this small rural hospital is well on the mend. "We've really had a nice turnaround the last couple of years," Janzen says.

Road to CAH Status

The road to becoming a CAH requires the hospital to meet a number of requirements, such as completing the financial feasibility study that Harris mentioned earlier. Other required measures include successfully completing a state survey of the hospital's policies, procedures and regulations; satisfying staffing standards; and having a formal agreement with a "network" hospital to which patients are transferred for services the rural hospital cannot provide.

Mary Lanning Hospital in Hastings is the Henderson hospital's network hospital.

Many rural hospitals lack the technical expertise in threading their way through preparatory

steps leading to CAH status. The Medicare Rural Hospital Flexibility Grant program authorized by Congress in 1999 provides funds to states for helping small, rural hospitals accomplish those steps.

In Nebraska, that funding is channeled to the Office of Rural Health in the Nebraska Health and Human Services System (HHSS) and the Nebraska Hospital Association. Those entities assist rural hospitals in their conversion to CAH status. John Roberts of the Nebraska Hospital Association and Dennis Berens in HHSS were tremendous help in getting the Henderson hospital ready for the survey, Harris says. "It was wonderful to get that help." The survey assesses how well the hospital is meeting standards for such things as policies, procedures and staffing.

Other Benefits

Harris says the process of converting to a CAH yields benefits beyond stronger financial health. For one thing, it has enhanced quality of care, she says. "We are such a small hospital that quality of care has always been our No. 1 goal around here. But the survey (required as part of the conversion to a CAH) did make us go back and review our policy and procedures. It had been 9 years since we last had a survey. So, we were due for a survey."

Henderson Health Care Services department supervisors meet monthly to review quality assurance and prepare presentations on healthcare outcomes to Henderson Health Services' medical staff and the board. The network hospital agreement includes provisions for the network hospital, Mary Lanning, to help Henderson Health Care Services monitor quality improvement. Through that arrangement, hospital department supervisors at Henderson consult on quality assurance with the quality improvement director at Mary Lanning twice a year.

"Improved cash flow (resulting from CAH status) has made us look forward to the future," Harris says. "I think it has improved the morale of staff, knowing there is a future in healthcare here in Henderson and will be for a long time." Also, she adds, board members are a lot more enthused about the hospital's operations. "They really want to know what is going on."

Several years prior to conversion to a CAH, the focus was mainly on just remaining in business. Now a formal strategic plan is in place. Retaining and recruiting employees and construction of new space that will house the clinic are some of the plan's goals that either have already been or will soon be reached. The plan will be reviewed annually, with its goals updated every 3 years.

Henderson Health Care Services can now do long-term planning with a realistic expectation of achieving its goals, Janzen says. The health care facility is second only to the school system in economic importance to the community, he says. Few industries bring more professional jobs to a community than a healthcare facility does, he notes. "These dollars are giving us more than just a healthcare bang," he adds. Construction of the new clinic, for example, represents economic activity for the community, he says.

The hospital, nursing home and assisting living facilities complement each other, says Hospital Administrator Harris. Goals beyond 5 years include expansion of the nursing home and assisted living facilities. "We know our community is an aging-in-place community. The waiting list for the nursing home is big. They (residents) do not want to go outside our community. They want to stay here. We know we need to increase the number of beds (for nursing care and assisted living)."

Janzen says, "Over time, had we closed the acute-care facility, we would have had difficulty maintaining the rest of the operation." One of the strong draws for a long-term care center is that residents don't have to leave the community for primary Health Care Services, he explains.

A theme in Henderson Health Care Services' strategic planning is being proactive in addressing the health needs of all ages in the community, Janzen says. That planning ranges from possibly adding an Alzheimer's unit in the long-term care facilities to such wellness programs as diet counseling, health screenings, and physical-fitness facilities in the basement of the clinic soon to be built.

Selling the Concept

With such strong local support for keeping quality healthcare facilities in the community, selling the concept of a CAH to residents was not a major task, according to Harris. A community meeting attended by several hundred people in June 1999, the annual board meeting in September of that year and four different local newspaper articles explaining what being a CAH means led to CAH status by December 1999.

That didn't mark the end of community information efforts, of course. Henderson Health Care Services keeps the community informed of its operations and status on an on-going basis. Two ways it does that are:

- Hospital staff-written articles about the hospital and its operations published regularly under a section titled "Health Beat" in the Henderson newspaper. "Right now, we are letting them (community residents) know what's happening

with the new clinic and fund-raising for the clinic," Harris says.

- One of the community activity reports presented at each monthly meeting of the Henderson Chamber of Commerce is Harris' report of what's happening at the town's healthcare facilities.

Harris says the No. 1 challenge for the hospital is attracting healthcare workers. "It's not really salaries," she says. It's social factors, such as limited activities and shopping options in a small town.

But the hospital and its board are addressing that, too. "We are working hard at recruiting our own local students to get them to come back," she says. "We just got done working with a shadowing program." Through that program, the hospital works with high school counselors to bring in high school students to shadow healthcare workers in their jobs at the hospital.

Also, the hospital will pay students' tuition for training to be radiological and laboratory technologists, which the hospital is "in desperate need of," says Harris. Paid tuition for that training is also available to hospital employees, she adds.

What if Henderson Health Care Services, Inc., hadn't become a CAH? The hospital's upgrading probably wouldn't be possible, Harris says. And maybe the aforementioned two new physicians wouldn't be coming to the hospital clinic, she conjectures.

She believes the attention to planning and stronger financial footing achieved through the CAH program are leading the way to clearly better Health Care Services in the community.

"We just had our CAH survey, and there were no deficiencies," she says.

CRITICAL ACCESS HOSPITALS

A NEBRASKA Story

FAIRBURY: Jefferson Community Health Center

BY DAVE HOWE

If, as that old adage goes, "No man is an island," it's certainly also true a rural hospital isn't one, either. Not if the hospital is fulfilling its obligation of providing quality rural healthcare.

For proof of that assertion, look no further than Jefferson Community Health Center(JCHC) in Fairbury, Nebraska, a southeastern Nebraska community of 4,300, just 10 miles from the Kansas border.

Words and phrases such as "networking," "working relationship," and "helping rural hospitals work more closely together" are sprinkled throughout Bill Welch's conversation. He's discussing JCHC's activities under the federal critical access hospital (CAH) program enacted by Congress 5 years ago.

The program is aimed, in part, at helping rural hospitals avoid being marooned from outside resources that can make a significant difference in how well a rural hospital can meet its residents' healthcare needs.

Features in this program pave the way for CAHs to work together, re-enforcing each other's efforts to provide quality rural healthcare, says Welch, JCHC's CEO.

But back to that in a moment.

JEFFERSON COMMUNITY HEALTH CENTER

- 25-bed hospital with 15 acute-care beds.
- Converted to a CAH a little more than 2 years ago.
- 40-bed long-term care unit.
- Hospital building 40 years old.
- Located in southeast Nebraska, 10 miles from the Kansas border.
- Provides broad scope of healthcare services, ranging from home health to sleep studies.
- Patient census is approximately 60% Medicare and 7% Medicaid

FOR FURTHER INFORMATION, CONTACT:

Bill Welch (402) 729-3351
Dave Palm (402) 471-0146
John Roberts (402) 421-2356
Dennis Berens (402) 471-0142

Financial Side

There's also the financial side to being a CAH. That's the cost-based reimbursement that CAHs receive for the healthcare they provide to Medicare and Medicaid patients.

At the 25-bed hospital in Fairbury, where patient census is approximately 60% Medicare and 7% Medicaid, cost-based reimbursement has made it possible to replace some outdated equipment and add new equipment and services. "We have started doing total knee replacement here," Welch says by way of example of new services. "I don't think we would have been able to offer some of the services we have or update the equipment we have without critical access," he notes.

The hospital also gets help with equipment purchases from the Jefferson Healthcare Foundation, according to Welch.

JCHC, with a 40-year-old hospital building and an attached 40-bed nursing home, provides a long list of healthcare services, ranging from home health to sleep studies. Construction of an assisted living unit is to begin this fall.

A feasibility study, one of the requirements for converting to a CAH, indicated that the hospital would realize "a couple hundred thousand-dollar favorable impact" from operating as a CAH, Welch says. The actual financial outcome shows the impact "a little bit more than that, even," he adds.

For many rural hospitals, he says, "I know it (cost-based reimbursement) has made a lot of difference between being open and closing." While that's an important element of the CAH program for JCHC, the hospital doesn't depend on it to keep its doors open, according to Welch. "The hospital has always operated in the black."

Network's Value

Equally important as cost-based reimbursement for this health center, Welch says, is the CAH program's hospital network system, whereby each CAH is networked with one or more regional hospitals. This is what Welch was referring to in the early part of this story.

The Fairbury health center, which has always worked closely with BryanLGH in Lincoln, is now formally affiliated with BryanLGH in a network under the CAH program. More than a dozen other CAHs are also part of the network

Through that networking arrangement, a CAH enjoys not only the collaborative strength of the network hospital but other CAHs in the network. They can join together in identifying and solving problems, doing peer reviews and bringing training and education to their respective hospitals on a cooperative basis at less cost than each hospital could acquire those services on its own.

Additionally, the CAH program creates a system through which the state assists CAHs in meeting required healthcare standards under the CAH program.

The latter is funded in part through the Medicare Rural Hospital Flexibility Grant Program, the product of 1999 federal legislation. The Office of Rural Health in the Nebraska Health and Human Services System (HHSS) allocates these Federal funds to CAHs in Nebraska. The funds underwrite technical assistance to help cash-strapped rural hospitals complete the necessary feasibility studies, planning and other processes leading to CHA designation and the transition that follows. Flexibility grant funds are also allocated by the Office of Rural Health to CAH networks for such programs as on-going education and training.

Those elements of the CAH program count importantly in helping JCHC improve its healthcare services to the 10,000 residents in the southeastern Nebraska area served by the hospital, Welch says.

"I think having to have a network hospital. . .has been very helpful in areas such as quality assurance," Welch says. "That's been a real benefit. I think our working relationship (with BryanLGH) is a lot closer than what it was before."

Such functions as peer reviews, quality assurance improvement and hospital policies and procedures are addressed through the CAH network, Welch notes.

Another Group

"We also belong to another group called the Blue River Valley Network," Welch says, explaining that this organization includes a group of rural hospitals—most of them CAHs—who have in common an interest in providing quality healthcare in rural areas. This organization also fosters member hospitals' ability to work together, Welch says.

A patient satisfaction survey is one example of activities carried out jointly through the Blue River Valley Network. Now hospitals in this organization are conducting an employee satisfaction survey.

"The most important thing we do is get together each month and talk," Welch says of the BryanLGH and Blue River Valley Networks. Both networks provide an opportunity for CAH personnel to meet in groups by area of responsibility— such as plant operations, dietitians, foundation directors and housekeeping—to exchange ideas, he says.

Welch credits personnel in the Office of Rural Health in HHSS and the Nebraska Hospital Association for playing a crucial role in getting the CAH program off the ground in Nebraska and advancing it to a premier program.

One of the first steps toward becoming a CAH is a survey of policies and procedures in which a rural hospital seeking CAH conversion must meet CAH standards. It's a helpful process, Welch says. "It makes you reassess what you're doing."

Helping Hand

Dave Palm from the Office of Rural Health and John Roberts of the Nebraska Hospital Association (now a private contractor with the association) played key roles from the start, when JCHC sought CAH status a little more than 2 years ago, according to Welch. "They did a very good job of preparing us for the survey and helping us meet all of the requirements for becoming a CAH.

"This state works very hard with the Federal government in getting to know the rules and regulations and then working with us. We're very fortunate in this state to have that. Some of the other states didn't have that. Those states are finally coming around a little bit, but Nebraska is way ahead of everyone else," Welch says.

Gaining community acceptance of conversion to a CAH "wasn't difficult at all," Welch says. "Before we ever did anything, we sat down and talked to the (hospital) board and medical staff. We explained what it was all about. Then we went out to the community and explained to some of the civic groups (Kiwanis, Rotary and the Chamber of Commerce)," he says, "so that when they saw it in the newspaper, they wouldn't be surprised. We did our homework before we converted. Everybody was very understanding. So, there was no resistance at all. In fact, the medical staff was very supportive of it."

The hospital has a public relations and marketing director. "She does an excellent job of putting out information on the radio and in newspapers of what services we have," Welch says. "We do that on an on-going basis."

Through its various efforts in conjunction with the CAH program, JCHC is no rural healthcare island.

CRITICAL ACCESS HOSPITALS

A NEBRASKA Story

WEST POINT: St. Francis Memorial Hospital

BY DAVE HOWE

Convert to a Critical Access Hospital?

The first time management and the board of directors at St. Francis Memorial Hospital at West Point asked themselves that question, the answer was a flat "no."

"We went to the board and recommended not to do it," recalls Hospital Administrator Ronald Briggs. "When we first looked at being a Critical Access Hospital (CAH), we heard negative things." Briggs says. . .comments such as, "You'll have to cut back on services" and, "You won't be a full-service hospital." Worst of all: "You'll have to kick patients out," a remark based on the so-called "96-hour rule" that limited length of stay for an acute-care patient to 96 hours. That rule was a major obstacle. "We didn't want to have to send patients away," says Briggs.

Deeper digging into the issue turned up a little different picture. Visits with doctors and staff at other CAH hospitals led to more positive discoveries about operating as a CAH. Most important of all, legislation changed that 96-hour rule. The limit now applies to the average length of stay for all acute-care patients, not each patient.

"We probably made our request for a (CAH) survey within a month of that change," Briggs says. That was the clincher.

Telling the Story

The CAH story was carried to St. Francis doctors, staff, constituents and the community in general. Newspaper articles, presentations at Chamber of Commerce meetings and other community gatherings, and a lot of person-to-person contact proved to be an effective way to get the word out, according to Briggs.

When time came for the board to once again make the decision on converting to CAH, "everybody was keen on the idea," he says.

This 25-bed facility that serves 16,000 to 17,000 people within a 1,600-square-mile area doesn't fit the popular notion of rural hospitals: no decaying building, aging exam rooms and equally gloomy financial statements.

True, the main three-story hospital structure that is nestled into a steep hillside that permits ground-level access to all three levels, was built with Hill-Burton funds a half century ago. But it's been extensively remodeled over the past 10 years. "It's quite modern," Briggs says proudly. It has a clinic, built in 1998. Two older clinics, which now serve other purposes, sit across the street. The hospital system includes an assisted living facility with 70 apartments.

Two words explain the high state of healthcare here: "Community support." Recognizing 7 to 8 years ago that it was either upgrade the surgery department or no longer be able to do surgery, the community answered the call. "A family gave us a farm to help pay for a new surgery department. And, the community donated $2.4 million for our new clinic to consolidate the two clinics in town," Briggs says.

ST. FRANCIS MEMORIAL HOSPITAL

- Serves 1,600-square-mile area with 16,000 to 17,000 residents.
- Area's main economic activities are agriculture, meat processing and fire-fighting equipment manufacturing.
- 26,000 patient visits to clinic annually; 14,000 visits at rehab facility.
- Medicare patients—both inpatient and outpatient—account for about 50% of the hospital's patients and about 55% of its dollar volume.

FOR FURTHER INFORMATION, CONTACT:

Ronald Briggs (402) 372-2404
Dave Palm (402) 471-0146
John Roberts (402) 421-2356
Dennis Berens (402) 471-0142

"People don't like to go to a place that doesn't look like it knows what it's doing," Briggs says. "We tried to do it (upgrade) in such a way that we didn't have to go out and have a big building project." Instead, funds were carefully targeted to make improvements where needed. That strategy was successful. "We have tried to not borrow a lot of money. We've been frugal."

A Red Flag

So, it wasn't so much that this hospital was in financial straits when it converted to CAH status in April 2000 but rather, it was where the hospital was headed in this medically under-served, health professional shortage area of rural northeastern Nebraska. There was a red flag—a projected shortfall from outpatient services for Medicare patients. Cost-based reimbursement under CAH status would enhance the hospital's finances, Briggs explains.

Fifty-five percent of this hospital's outpatients are Medicare patients, according to Briggs. "We were really going to take a big hit on the Medicare patient side (without CAH status). We had a fear that we would not be able to keep up with salaries and wages during a time of shortages in medical professionals.

"The biggest thing CAH has done for us is allow us to recruit and keep the people we need to have for a good facility," Briggs says.

Medicare patients—both inpatient and outpatient—account for about 50% of the hospital's patients and about 55% of its dollar volume, according to Briggs. Only 5% to 6% of patients are on Medicaid in this area where the economy is mainly agriculture and agriculturally related industry that includes Wimmers, a processed-meat company; IBP beef packing plant east of West Point; and Smeals, a fire-fighting equipment manufacturer at Snyder, about a dozen miles to the southwest.

West Point also enjoys a strong retail market, attracting shoppers for groceries and other consumer goods.

62,000 Patient Visits

The hospital, clinic and assisted-living facility contribute significantly to the local economy, ranking only behind the packing plant and fire equipment manufacturer, according to Briggs. Employment at the St. Francis complex of healthcare services total some 225 employees, many of them professionals, creating a strong demand for goods and services locally. More importantly, Briggs notes, the retail trade brought to town 26,000 patient visits at the clinic and another 36,000 patient visits at the hospital.

"In the 2 years we've been a CAH, we've done so many good things from the perspective of services," Briggs says. Citing an example, he says surgical services have been expanded with two sugeions who came to the community. They joined the four family practice doctors employed by the hospital, on the strength of the hospital now being more financially stable.

"I feel we are definitely stronger financially than we would have been (without CAH). We have better staffing than we would have had without CAH. Besides the six physicians, the hospital's staff includes three physician assistants, a nurse practitioner, more than 30 RNs and LPNs, and five X-ray technicians.

Better Hospital

CAH status has done more than undergird staffing. It's helped St. Francis Memorial hospital be a better hospital. The initial survey for converting to a CAH is more stringent than the previous survey process the hospital was using, according to Briggs. A year after that initial survey, a follow-up survey was done to confirm that the hospital is doing what it said it would do, he adds. That has led to a lot of upgrading in policies and procedures here, according to Briggs.

St. Francis Memorial Hospital is networked with Immanuel Hospital, part of the Alegent hospital system in Omaha. The CAH program requires a CAH to be networked with a major hospital to which patients can be transferred when their care needs exceed what the CAH can provide.

"They (network hospital) have been good for us," Briggs says. It's less clear how the CAH linkup benefits them, he adds. "I think they thought we might bring them a lot of referrals." But doctors have a lot of connections," Briggs says, which doesn't always guarantee referrals to the network hospital.

A couple of the ways in which he sees St. Francis benefiting from the network affiliation are:

- St. Francis physicians participate in a broader-based peer review. The reviews are done through the network. That, in effect, creates a larger medical staff to do peer reviews.
- Affiliation with the network hospital provides opportunities to strengthen St. Francis' quality improvement program. Immanuel's quality improvement group reviews the program at St. Francis and makes suggestions. Through the Alegent buying group, St. Francis has access to the Premier Quality Improvement Project (a national project that includes 2,700 hospitals nationwide), which assists with grants for quality

improvement measures. The funds cover such things as sending nurses to quality improvement workshops.

Two examples of quality improvement measures at St. Francis Memorial Hospital involve pneumonia and heart patients in the emergency room. Time from when the pneumonia patient arrives at the emergency room until initial antibiotics are administered has been halved. Time between a heart patient's arrival and when an EKG is done has been reduced, with a goal of accomplishing that within 10 minutes.

The staff and board are more optimistic about the future, Briggs says, because of financial stability stemming in part from cost-based reimbursement for Medicare and Medicaid patients under CAH status. But that reimbursement doesn't pay all of the costs, he continues. There are certain non-allowable costs. Non-Medicare, insured patients must make up part of the mix. "If you had 90% Medicare, it (CAH) wouldn't work. If you were Medicare only, you would still struggle mightily."

CAH doesn't vanquish all concerns for the future, either. A shortage of nurses, radiology technicians and doctors—even though it's been said that we have too many doctors—is sobering, Briggs says. "Keeping quality staff in a rural area is going to be a key issue well into the future." However, the CAH program has done more for rural healthcare than anything else in the last 20 years," Briggs says.

CRITICAL ACCESS HOSPITALS

A NEBRASKA Story

AINSWORTH: Brown County Hospital

BY DAVE HOWE

In a way, Brown County Hospital in Ainsworth, Nebr., is undergoing a rebirth.

When it converted to a critical access hospital 2 years ago, it only had an acting administrator, says Elaine Hoppe, an RN and 10-year staff veteran who was there to see the hospital's conversion to critical access hospital (CAH) status.

She's watched this hospital grow since then to become a viable healthcare facility that serves not only the county's population of 3,500 but some of the residents from neighboring Cherry, Rock, Holt and Keya Paha Counties in north central Nebraska. Brown, Rock and Keya Paha are three of the poorest counties in the state, Hoppe says. Keya Paha, whose largest population center is Springview, with about 350 people, has no medical facility of any kind.

Hoppe has extensive knowledge of Brown County Hospital and its history over the past decade, which is why Dan Cole, who joined the hospital as its administrator just a year ago, designated her as the spokeswoman for this article. Her hospital responsibilities include quality assurance, social services, care management and risk management.

An upbeat tone is evident in Hoppe's voice as she outlines where this hospital was, where it's at now and where it hopes to go.

Thanks to cost-based reimbursement for Medicare and Medicaid patients under the CAH program, Brown County Hospital has gone from making do with old equipment and uncertain staffing to improved staffing, some new equipment and big plans for the future, Hoppe says.

Before CAH status, she says, "we were seeing about 40 cents on the dollar," meaning a recovery of 40 cents from every dollar of hospital expense. "County tax revenue contributed about 4% of the budget."

BROWN COUNTY HOSPITAL

- Serves residents in Brown County and four neighboring counties in north-central Nebraska.
- Hospital planning a bond issue on ballot in fall 2002 or spring 2003 to finance expansion.
- Concluded fiscal year 2002 in the black, its second fiscal year of operating as a CAH.
- Sixty-five to 70% of patient census is on Medicare.
- Network hospital is Good Samaritan Hospital at Kearney

FOR FURTHER INFORMATION, CONTACT:

Elaine Hoppe (402) 387-2800
Dave Palm (402) 471-0146
John Roberts (402) 421-2356
Dennis Berens (402) 471-0142

Bleak Past

That bleak past financial picture is painted by this hospital's patient census of 65% to 70% on Medicare and another 5% on Medicaid. Some of the remaining patients are uninsured.

Ranching and farming are this community's economic mainstays, Hoppe reminds. "We just don't have many people with a very high salary." Consequently, quite a few people do not have health insurance. Among those who do, it's not unusual for them to carry deductibles ranging from $2,000 to $3,000 per person. "It's really the only way they can afford it (health insurance)."

That's why cost-based reimbursement for Medicare and Medicaid patients plays such a crucial role in allowing this hospital to now operate close to if not in the black. Only 3% of its budget now

comes from county tax revenue, according to Hoppe.

When this hospital looked at its revenue stream after its first fiscal year of operating as a CAH, Hoppe says, it saw a positive impact of $150,000 in new revenue—a worthy ledger entry for a hospital of this size. The hospital ended its second fiscal year as a CAH on June 30, 2002, in the black, albeit just barely. "But we had made several purchases," Hoppe says. "Definitely, in the last 2 years, we would have lost money and we would not have been able to replace needed equipment (if not for being a CAH). In the year previous to becoming a CAH, the hospital showed a $58,000 loss."

Stability

What CAH has done is provide stability, says Brown County Hospital Board Chairman Jan O'Hare, Ainsworth. "That standing as a CAH has helped us tremendously. It has been a blessing for our area."

Prior to converting to a CAH, this hospital had seen a number of changes in administration, according to Hoppe. And it had seen very little maintenance. "Basically, nothing was done to the facility since it was built in 1971." A little peak built over the original flat roof that leaked and replacement of windows account for most of the improvements since the hospital's original construction, she says.

Equipment replacement had also been neglected. "So, what we ended up with is a lot of outdated equipment that we've been trying to replace," she says. "We just replaced our sterilizer, which had been here since the beginning of time." That was a $30,000 expenditure. "We also replaced our cardiac monitoring system," she continues.

Not Just New Machines

But the changes aren't just new machines. Now the hospital has a permanently named administrator, which wasn't the case prior to its conversion to a CAH. The hospital, which has a clinic across the street in Ainsworth, has a physician and a nurse practitioner. A second physician is scheduled to join the hospital staff at the end of August.

Another physician in private practice at his own clinic in Ainsworth, who employs a nurse practitioner, also practices at the hospital. Additionally, Hoppe says, Brown County Hospital and West Holt Hospital in Atkinson share a surgeon who splits his time between the two hospitals, 2 days a week every week at each hospital.

Brown County hospital's 75 to 80 total full- and part-time employees include about 10 RNs, five LPNs and a number of nursing assistants and ancillary staff, making the hospital and the school the community's two largest employers, according to Hoppe. "We're open 24-7, so that takes a lot of staff."

In August 2002, Brown County Hospital opened a three-chair, hemo-dialysis unit in the hospital.

Now the hospital board and management are looking ahead to the next step, a bond issue to finance hospital expansion.

"We've met with the county commissioners and hope to have it (bond issue) on the ballot this fall or next spring," Hoppe says. Among expansion and improvements the bond would finance are:

- More clinic space for visiting specialists from surrounding cities such as Omaha, Lincoln, Norfolk, Kearney and Grand Island to see patients.
- Expansion of the hospital's physical therapy area.
- Added space for a conference room and administration. Currently, a part of the hospital's dining and family area has been enclosed for an administrator's office.
- More space to provide privacy for patient admitting and the nurses' station.
- Updated patient rooms. That includes making them handicap-accessible.
- Added space and updating for labor, delivery and postpartum.
- Enlarged and updated emergency room to accommodate two patients at the same time.
- A cover to provide shelter from the weather for patient transfers by ambulance.

Hoppe says that having space in the hospital for specialty clinics that bring specialists to town is especially important in a community like Ainsworth, which has an older population base. The closest regional hospital is 3 hours away, not an easy trip for many elderly patients.

Turning Point

One of the biggest turning points in Brown County Hospital's decision to become a CAH, Hoppe says, was when the CAH program changed the "96-hour rule." That rule originally limited any individual acute-care patient stay to 96 hours in a CAH. After that the patient had to be ready to go home or be transferred to a regional hospital. Now the 96-hour limit applies to average length of stay for acute-care patients, "which means we can keep some patients longer," Hoppe says.

That's important, she continues. "For instance, we do bowel surgery and that type of surgery patient usually has to stay longer than 4 days." Citing another example, she points to a number of infants and small children who were admitted to the hospital with RSV this past year. "We had quite a few who were not ready to go home in 96 hours. We would have had to send them to a regional hospital 3 hours away."

Despite stays beyond 96 hours for some patients, the hospital is having no trouble keeping the average for acute-care patient stays below 96 hours, according to Hoppe. "Most months, we are under 72 hours."

There was some community wariness about converting to a CAH, according to Hoppe. One concern was that as a CAH, the hospital wouldn't be able to offer the same services as before. The perception was that a CAH hospital was a lower-status designation and as such would not be a "real hospital" anymore.

Those reservations among members of the community were addressed through a number of public meetings. People were encouraged to attend and ask questions. Articles in newspapers, along with question/answer sessions at meetings of local organizations were also avenues of making the community aware of what a CAH was and what it could potentially do for healthcare in the area.

Hospital Board Chairman O'Hare says, "Once we had the information, it was a go. There was no hesitation on anybody's part (on the board and hospital staff)."

Of course, a hospital doesn't just one day decide to declare itself a CAH and, poof!, it's a CAH.

Survey Value

Among the processes it must complete is an initial survey of hospital policies and procedures by a survey team from the state Health and Human Services System (HHSS), followed by another survey a year later to see how well recommended changes were implemented.

Hoppe feels that while Brown County Hospital has always provided quality healthcare, the survey process required for becoming a CAH has been helpful. The initial survey offers a lot of input on hospital policies and procedures. "It's more of a helpful survey," Hoppe says, in which the surveyors point out areas where the hospital needs to make improvements. The required followup survey under the CAH program verifies that needed changes were made, she says. "The State has been very good in those surveys."

Another aspect of the CAH program that the hospital finds very helpful, according to Hoppe, is affiliation with a regional hospital that serves as a network hospital. Brown County Hospital, along with 11 other CAHs throughout central and southwest Nebraska, is networked with Good Samaritan Hospital at Kearney.

Saving Travel

"Our network is pretty active together," Hoppe says. The hospital meets quarterly to exchange information among hospitals in the network. Employee education through a service (called HealthStream) contracted by the network delivers various educational programs via the Internet to staff at the CAHs, Hoppe explains. "It is a big thing for us because of the distance we have to travel for in-services. All of our in-services are done through the Internet, and part of the deal (through HealthStream) was a computer and printer (at the hospital)." Those in-services, which are required by law, include such topics as fire safety, patient rights and infection control.

Continuing to acquaint the public with the hospital's services and needs is important, especially now that the hospital is seeking a bond issue for expansion and upgrading, Hoppe says. "In fact, for the past 8 months, we've been holding quite a few tours through our facility." These tours, held about once a month, focus on showing the public how healthcare is shifting from inpatient care to more emphasis on outpatient services.

With fewer inpatients and more emphasis on outpatient care, it's hard for the public to understand why the hospital needs more room, Hoppe says. One purpose of the tours is to answer that seeming contradiction.

"We feel that without having become a CAH, we would probably not even be talking about a remodeling project, because financially it was not even in the picture," Hoppe says.

CRITICAL ACCESS HOSPITALS

A NEBRASKA Story

CALLAWAY: Callaway District Hospital

BY DAVE HOWE

It's a question for addressing all kinds of decisions, ranging from personal to business relationships: "Are you better off with (fill in the blank) or without (fill in the blank)?"

That, in a way, is where Callaway District Hospital stood a couple of years ago, as it pondered whether it should convert to critical access hospital (CAH) status.

Was this 12-bed hospital losing money? No. Was it ready to close? No. If it didn't convert to a CAH, would it be forced to close? No.

But the "no" answers to those questions didn't answer the CAH question for this hospital in Callaway, Nebr., population 627, near the South Loup River in central Nebraska's farming and ranching country.

CALLAWAY DISTRICT HOSPITAL

- Converted to a CAH 2 years ago.
- 12-bed hospital in Callaway, a central Nebraska farming and ranching community.
- Hospital's total employment, 35
- Medicare accounts for 63% of inpatient admissions and 69% of inpatient revenue.

FOR FURTHER INFORMATION, CONTACT:

Marvin Neth (308) 836-2228
Dave Palm (402) 471-0146
John Roberts (402) 421-2356
Dennis Berens (402) 471-0142

Accountant's Urging

"Our accountant said we needed to look at the CAH program," says Marvin Neth, the hospital's administrator. A feasibility study, part of the process for conversion to a CAH, indicated that additional revenue under the CAH program's cost-based reimbursement for Medicare patients would be a financial benefit to the hospital, he says.

"We've never tried to make tons of money," Neth says. "All we've ever wanted was a zero-based budget." Only $40,000 of the hospital's $1 million-plus budget comes from a tax subsidy, according to Neth. "We figure our mission is to provide healthcare appropriately and not have a (financial) loss."

Community support through the Callaway District Hospital Foundation also helps the hospital's bottom line. The foundation has, among other things, helped with some of the hospital's equipment purchases and provides tuition assistance for education of staff.

So, better off with conversion to a CAH, or better off without it? The hospital board and management concluded the hospital would be better off with it. Although the hospital wasn't operating at a loss, its revenue stream would be better as a CAH. "The financial benefit is what swayed us," Neth says.

"It's not a windfall program," Neth says. But he adds: "At least when we make a decision that costs us a dollar, we may get 75 cents back." That certainly doesn't create any temptation to buy equipment the hospital doesn't need, he says. "It does help, however, in those situations where you're paying out extra payroll."

Recruitment Help

Neth goes on to explain that the cost-based reimbursement for Medicare patients under the CAH program helps this hospital recruit and retain employees through a better pay scale. "Wages are going up all over. It's almost a bidding war. And people are more mobile and more willing to drive

(long distances) to jobs," Neth says.

Also, it's harder to recruit from outside to a small community like Callaway. If a recruited employee is married, it may take two jobs in the community to land that person on the staff, according Neth, who makes his point with this hypothetical situation: "You want to hire an RN who happens to be married to a banker and you don't need a banker in the community."

Cost-based reimbursement is a safety net, which Callaway District Hospital relies on heavily for being a competitive employer. "I do think it would have been more difficult to make decisions on pay increases and replacing some equipment without knowing where some of that money is going to come from," Neth says. "But I don't know that we did anything that we wouldn't have done (without the CAH program). We just did it sooner and better."

Medicare Numbers

Sixty-three percent of the hospital inpatient admissions are on Medicare. A little over 3% are on Medicaid. In terms of patient-days, 70% are Medicare, because Medicare patients tend to require longer hospital stays, Neth explains. Medicare accounts for 69% of inpatient revenue, while Medicaid accounts for 3.3%, according to Neth. Forty-five percent of outpatient revenue is Medicare, while 6.5% is Medicaid.

Those figures point to the importance of cost-based reimbursement to this hospital. "When we have to compete for nursing wages, we know we're going to get a portion of that money reimbursed to us," Neth says.

Callaway District Hospital's staff includes one physician, three physician assistants, nine RNs, four LPNs, two lab technicians, one radiology technologist, two limited radiographers and other support staff.

The hospital, which has swing beds for intermediate care but not long-term care, does not operate a nursing home. However, a nursing home is located in Callaway, Neth says.

The hospital moved into a new building in 1979, built with a $1.1 million bond issue approved by the voters a couple of years earlier. In 1986, the hospital added an outpatient addition for services the hospital was beginning to provide. "We just didn't have separate rooms for outpatient exams and clinics, for physical therapy, stress tests and scopes," Neth says.

The original hospital building, which is attached to the current hospital and is still owned by the Callaway hospital, houses a clinic in which a physician practices independently of the hospital.

Through the community's approval of the bond issue and continuing generous support from the Callaway District Hospital Foundation, the hospital has been able to remain a viable healthcare facility in this rural area, according to Neth.

"We're talking about adding more clinic space. We're hoping that in some way we can expand," Neth says. The hospital's patients come from a 694-square-mile hospital district that the hospital began serving years ago, as well as patients outside the boundary of that historically served area today. In fact, more than half the hospital's patients come from beyond the hospital district's boundary. The next closest hospital is about 20 miles away, at Broken Bow.

9,000 and Counting

The hospital was closed for 1-1/2 years back in the early 1970s, when it had no physician. When the hospital re-opened in 1974, it began numbering its charts, starting with "1". "Today, we're currently over 9,000," says Neth, meaning that more than 9,000 patients have come to Callaway District Hospital for inpatient and outpatient healthcare since it reopened.

Neth sees the hospital as "absolutely essential" to the economic and civic well-being of the community it serves. The hospital, school and nursing home are the three biggest employers in Callaway. "The hospital is one of those places that pump new dollars in. We're not just trading dollars around," he says, explaining that "Medicare and Medicaid dollars are new dollars."

While his hospital considers CAH cost-based reimbursement and the future of the program important to providing healthcare services to the community, there's more for a CAH to consider.

As required under the CAH program, each CAH hospital must be formally affiliated with a regional hospital that serves as a network hospital. Good Samaritan Hospital in Kearney is the network hospital for Callaway District Hospital and 11 other CAHs. That CAH hospital network is a valuable aspect of the CAH program, Neth says.

Under Good Samaritan Hospital's coordination, the network "pulls all 11 of us (CAHs) together in various meetings and projects to talk about quality care concerns and cooperative efforts," Neth says. "That's a good process. We continue to meet on a regular basis. I'm sure that has a positive effect on patient care."

"We'd like to think that we have always provided quality care," Neth says. But now personnel from his hospital and others in the Good Samaritan network get together to address quality assessment and coordinate how to improve quality of care. Without the CAH program network, that probably would not occur, Neth says.

A NEBRASKA Story

ALBION: Boone County Health Center

BY DAVE HOWE

Sometimes numbers tell a story better than words.

Numbers portray clearly how modern healthcare practices are trending toward more outpatient care and less inpatient care at Boone County Health Center in rural east-central Nebraska. They mirror the way quality healthcare delivery is changing, whether it's in an urban or rural setting.

Here's what the figures show at this 25-bed hospital and its several clinics in surrounding towns: 53,000 outpatient visits and 1,000 inpatient admissions a year. Other numbers: 35,000 lab tests, 10,000 radiological exams and about 500 surgeries annually. Sixty-five percent of this facility's total revenue is from outpatient services.

BOONE COUNTY HEALTH CENTER

- Located at Albion, in east-central Nebraska.
- 53,000 outpatients annually, with 65% of total revenue from outpatient services.
- 1,000 inpatient admissions annually.
- Serves all or parts of seven counties.
- Clinics in seven towns.
- Currently in a construction phase, adding 19,000 square feet of space, plus renovation of 3,000 square feet.
- Annual operating budget of about $15 million.

FOR FURTHER INFORMATION, CONTACT:

Vic Lee (402) 395-2191
Dave Palm (402) 471-0146
John Roberts (402) 421-2356
Dennis Berens (402) 471-0142

More Outpatient Services

In reciting those numbers, Boone County Health Center Administrator Vic Lee points out that many older rural hospitals were built with emphasis on inpatient care, not the type of care being provided today.

Adapting to that change in healthcare delivery is in part what's driving new construction at Boone County Health Center. "We are currently building a brand new hospital," he says. This latest addition has 19,000 square feet of space. Three thousand square feet of renovated space in the old structure will tie new and old together. A lot of that construction involves outpatient focus, he says, such as new lab and X-ray facilities and examination rooms for clinics by specialists from Lincoln, Omaha, Norfolk and Grand Island.

When it's all done, this hospital will have a brand new emergency room, ambulance garage, surgery department, admitting area, lab and X-ray departments and patient rooms. It's all to be completed by September 2003. "We also built a new clinic in Fullerton last spring," Lee says.

The hospital, attached clinic and clinics in the surrounding towns of Elgin, Spalding, Newman Grove, Fullerton, St. Edward and Cedar Rapids serve 10,000 residents in all or parts of seven counties. Physicians in the St. Edward and Cedar Rapids clinics practice in connection with Boone County Health Center but are not hospital employees.

Hospital's Adaptation

The array of clinics and a series of construction projects over the years trace this hospital's adaptation to the community's changing healthcare needs, right up to the current construction. There was a new addition to the original 1949 hospital structure in 1976, another in 1987 and yet another in 1994—creating a total 35,000 square feet, including the hospital's attached clinic. The hospital's radiology services

include CT, nuclear medicine, mammography, ultra sound and general X-ray. As of August 2002, a mobile MRI was permanently parked on-site, available 24 hours a day, 7 days a week.

Along with the recent din of backhoes, drills, hammers and saws that are positioning Boone County Health Center to meet its rural healthcare consumers' changing needs, an important change occurred a couple of years earlier for this hospital. That's when the hospital converted to a critical access hospital (CAH).

As a CAH, the hospital receives cost-based reimbursement for its Medicare and Medicaid patients. Fifty-five percent of the patients at the hospital and its clinics are on Medicare, according to Lee. About 3% to 4% are on Medicaid.

"The conversion to critical access provided a shot in the arm for us, financially," Lee says. "It's given us some opportunities that we would not otherwise have had. It's given us the ability to update a lot of outdated equipment."

The program has also helped augment financing for some of the current construction, he notes. Without the cost-based reimbursement for Medicare and Medicaid patients, he says, Boone County Health Center "probably wouldn't be in its current building project." But he's quick to add that CAH status for the hospital is not the difference between this hospital existing or not existing.

Boone County Health Center follows a strategic plan that its board, medical staff and management team review biannually, according to Lee. "We look at what was completed, what wasn't completed and why—and see what we need to continue to work on and what are new areas we need to develop. That gives us an agenda for the next 2 years."

The CAH program requirement that patient stays in acute-care beds not exceed an average of 96 hours hasn't been a problem for this hospital, according to Lee. "Our length of stay has been excellent for many years. It's been down to 72 hours or less, so it's never an issue," he says. "If we see that a patient is going to require a longer length of stay (exceeding 96 hours) or more acute care than we can handle, we transfer the patient to BryanLGH (in Lincoln)."

Community Economic Force

The primary role for a rural hospital is providing quality healthcare. But at the same time, it represents an economic benefit to the community it serves. While production agriculture and agriculture-dependent businesses dominate the economic base here, the hospital and its clinics count significantly in the area's economy. The hospital's operating budget is just under $15 million, which includes a $5 million annual payroll, according to Lee.

"We are the largest employer in the county (Boone) with more than 200 employees," he says. Those include six physicians, the two aforementioned physicians at the hospital's clinics but not on staff, and two physician assistants. "We have some employees who drive up to 60 miles to work here," he adds, pointing out that the economic impact of the hospital also touches those communities from which hospital employees commute.

And there's the civic impact. Lee says the hospital encourages its employees to be as active as possible in their respective communities. A number of employees serve on public health and civic boards in their communities and participate as leaders in school and youth organizations.

Part of the process for a hospital seeking CAH status is a survey that insures that the hospital's policies, procedures, regulations and staffing meet standards under the CAH program. "That took us some time to get all of that put together," Lee says. "The Nebraska Office of Rural Health and Nebraska Hospital Association are very helpful, probably more helpful than any other state in helping their hospitals become a CAH," he adds. "That's proven by the number (58) of critical access hospitals we have (in Nebraska). I think there are only a handful of hospitals in the state who could qualify who haven't yet qualified."

Under The CAH program, each CAH must be affiliated with a regional hospital that serves as a network hospital coordinating such programs as training and education, peer reviews and quality assurance for CAHs in the network.

Network Resources

"The network has tremendous resources for us," says Lee, whose hospital is part of the BryanLGH network, one of 11 CAH networks in Nebraska.

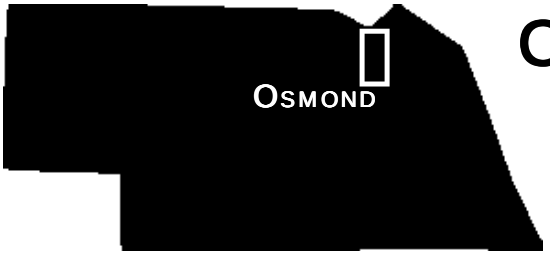
The BryanLGH network, in turn, is one of three CAH networks that are combined into a still larger hospital group called the Heartland Health Alliance Critical Access Hospital Collaborative Network. That strengthens still further the network's capacity to bring a broad array of training, education and other programs to its CAHs.

Regular newspaper articles and talks before such civic groups as Kiawanis and local Chambers of Commerce are one way this hospital tries to keep the public informed of how it is working to bring quality healthcare to the community, Lee says. But he doesn't believe that most healthcare consumers would recognize the term "CAH."

"The public wants convenience and good care. As long as we deliver that, I don't think they care what term we are called."

A NEBRASKA Story

OSMOND: Osmond General Hospital



BY DAVE HOWE

Operating a rural hospital could be likened to steering a large ship. A ship can't turn on a dime. Nor can a hospital. Obstacles along its route must be anticipated to allow course correction in time to steer clear of trouble.

That analogy comes to mind when listening to Osmond General Hospital administrator Celine Mlady describe how that hospital managed to keep from running aground on the financial shoals that threaten many rural hospitals.

The hospital was about a quarter of the way through the year 2000 when its board and management decided to "begin in earnest" to seek CAH status, according to Mlady. "We weren't in the red yet. . .but we saw declining revenues," she says. "The writing was on the wall. It was only going to get worse. It wasn't going to get better."

Sure enough, half way through the year, the hospital was in the red. Time for a course correction!

Before the year was out, the hospital had applied for CAH status. Five months later, on May 1, 2001, Osmond General Hospital was designated a CAH, qualifying the 25-bed, northeast Nebraska rural hospital to receive cost-based reimbursement for Medicare and Medicaid patients.

Eighty percent of this hospital's patient census is Medicare. Another 2% to 3% is Medicaid. Serving such a large proportion of patients at below cost of service augured poorly for this hospital to continue on that heading.

The financial feasibility study done in conjunction with application for CAH status had projected that the hospital would be in its second year of losing money by now, had it not converted, Mlady says. "It was that 'in-the-red' that made us decide (on CAH status)."

In the financial feasibility study leading up to conversion, auditors projected that CAH status would result in about $200,000 more revenue over a year's time, versus not being a CAH. "And that's about where we're at," says Mlady, at the close of the hospital's first year as a CAH.

OSMOND GENERAL HOSPITAL

- Serves a rural population of about 5,000 people in rural northeast Nebraska.
- Eighty percent of patient census is Medicare.
- Critical Access Hospital status improved revenue by about $200,000 a year.
- Achieves professional improvement through affiliation with hospital network and its own internal professional improvement programs.

FOR FURTHER INFORMATION, CONTACT:

Celine Mlady, (402) 748-3393
Dave Palm, (402) 471-0146
John Roberts,(402) 421-2356
Dennis Berens (402) 471-0142

Seamless Transition

Prior to the conversion, the issue was discussed among board members, doctors and other hospital staff, along with getting word out through local newspaper articles. "It was a seamless transition, as far as the public was concerned," Mlady says. "It wasn't as hard as I thought it was going to be. It sounded daunting. But, one step at a time, we worked through it."

Located in Osmond, population 750, the hospital and its clinics in Wausa and Randolph, plus a satellite clinic in Coleridge, serve a population of approximately 5,000 people in Pierce County and parts of Knox and Cedar Counties. The hospital employs two physicians, one of whom rotates between two of

the clinics in this medically under-served and health professional shortage area of the state. A third doctor, whose practice is independent of the hospital, also serves as a staff physician.

The hospital was built in the mid-1970s. Only part of the current structure's basement has been retained from the original hospital structure that was built here in 1945 as a Catholic hospital.

The hospital has 15 acute-care beds with the remainder being long-term-care beds, according to Mlady. "We're a swing-bed hospital." Osmond has no nursing home, she explains, so some patients who can't go home in a few months choose to make their home here in a nursing-home type of situation.

Competitive Pay

Due in part to a steadier financial course under CAH status, Mlady says, the hospital is able to fairly compensate its employees for the work they do. "We need to compete and pay our employees fairly. They are important to us and we want to retain them. That is one thing that has helped us keep up." Annual turnover is very low—less than 3%, she says. But healthcare positions, when they do come open here, can be difficult to fill. "The last time we had an opening, it took a good 6 months to fill."

Employment among the hospital and its clinics totals about 100 people, including 15 RNs, 17 LPNs, two respiratory therapists, a half-time pharmacist, a radiology staff person and three laboratory staff members.

The hospital and school system are the two largest employers in this community. But the economic base is primarily agricultural. A new ethanol plant is going up 5 miles west of town, bringing about 100 construction workers to the area. The plant, once it's completed, will be operated by about 30 employees, according to Mlady. "We're hoping they will choose our hospital for their healthcare support system."

Other major area employers include Peterson Ag Systems, Inc., an irrigation equipment manufacturer, and Battle Creek Cooperative, an ag coop. They represent a pool of potential healthcare consumers.

Looking Ahead

The hospital is now looking toward making exam rooms better-suited for patients seeing visiting specialists from such cities as Norfolk; Omaha; Sioux City, Iowa; and Yankton, S. Dak. Alterations to provide more privacy in the hospital's patient admission area, a CT scan (maybe a couple years down the road)and general sprucing-up of hospital facilities are in the planning stages. "We need to look as good as we are," Mlady says.

But more than physical facilities make up this hospital's course headings. Physician retention, workforce issues and scholarship programs "to grow our own a little bit" are part of this hospital's route into the future.

An example of the latter is $1,000 to an employee who trains to become an RN. Four scholarships are offered each year to high school students in Osmond and towns with the hospital's clinics. Each of these scholarships provides $250 annually, renewable up to 4 years, for a high school student studying in a health-related profession.

The hospital emphasizes professional improvement through training and education in different forms, according to Mlady. Web-based education for employees is one approach. Another is speakers who come to the hospital to make presentations. Staff viewing of satellite programs that originate from Mountain Plains Health Consortium based in Rapid City, S. Dak., is yet another.

Professional enhancements such as those are part of a well run hospital, whether it's a CAH or not. But Mlady does say: "We're feeling more relaxed and optimistic about the future. We've always felt we are a strong hospital and do a very good job. It (CAH status) just helped us all feel a little more comfortable."

It isn't only the cost-based reimbursement for Medicare and Medicaid patients that count in operating as a CAH. For example, the survey process leading to CAH designation can be a plus for a hospital. It was "very, very helpful," Mlady says.

Network Advantages

"I found with our most recent survey that our staff asked a lot of questions, and the advice was very helpful." The purpose of the survey, of course, is to insure that the hospital is complying with regulations, "and it's always good to know that you are," Mlady says.

Another advantage of being a CAH is the linkup with a network hospital, which in Osmond General Hospital's case is BryanLGH in Lincoln, 150 miles to the southeast. That hospital is "very, very available to us for guidance," says Mlady. Through the relationship with the network hospital, Osmond General Hospital can work with a large group of hospitals(23 hospitals)to compare notes on quality assurance and participate in physician review programs. Through this collaborative network, BryanLGH and three other large hospitals (Mary Lanning in Hastings, Faith Regional in Norfolk, and Great Plains Regional Medical Center in North Platte) have expertise

they are willing to share with other network hospitals, Mlady says.

This arrangement offers an opportunity for the hospital at Osmond and others in the network to compare quality assurance data and do problem-solving through formal get-togethers every month to every other month, according to Mlady.

Osmond General Hospital has its own quality assurance plan, through which it compares various quality issues such as patient stays, mortality rates and timeliness of administering antibiotics.

"You should be able to walk into any hospital in Nebraska and receive the same quality of care," Mlady says. The hospital's quality assurance committee meets monthly to measure various aspects of quality improvement and receives input from personnel who have direct patient contact.

Through a quality improvement report provided by the Nebraska Hospital Association, the hospital at Osmond can compare its quality improvement performance with that of other hospitals.

Mlady sees the CAH program as a way to enhance networked hospitals' ability to provide quality healthcare in rural areas. "I worry about some negative changes in the CAH program that will cause us to lose the program. CAH is such a small percentage of the overall Medicare budget. What a great impact this program has had for such a large geographic area."

A NEBRASKA Story

REGIONAL HOSPITALS:

BryanLGH Medical Center, Lincoln
Mary Lanning Memorial Hospital, Hastings
Great Plains Regional Medical Center, North Platte
Faith Regional Health Services, Norfolk

CRITICAL ACCESS HOSPITALS:

Crete Area Medical Center, Crete
Community Medical Center, Inc., Falls City
Jefferson Community Health Center, Fairbury
Brodstone Memorial Nuckolls County Hospital, Superior
Warren Memorial Hospital, Friend
Henderson Health Care Services, Henderson
Community Memorial Hospital, Syracuse
Cherry County Hospital, Valentine
Nemaha County Hospital, Auburn
Creighton Area Health Services, Creighton
Butler County Health Care Center, David City
Tilden Community Hospital, Tilden
Boone County Health Center, Albion
Antelope Memorial Hospital, Neligh
Saunders County Health Services, Wahoo
Providence Medical Center, Wayne
York General Hospital, York
Osmond General Hospital, Osmond
Memorial Health Care Systems, Seward

FOR FURTHER INFORMATION, CONTACT:

Colleen Chapp (402) 481-5192
Mike Ellis (402) 245-2428
Al Klaasmeyer (402) 269-2011
Dave Palm (402) 471-0146
John Roberts (402) 421-2356
Dennis Berens (402) 471-0142

LINCOLN: BryanLGH

BY DAVE HOWE

Auto industry icon Lee Iacocca, in his autobiography Iacocca, cites the importance of team-building that led to such automotive successes as the Mustang at Ford Motor Company and the minivan at Chrysler Corporation, the latter a company that Iacocca's management style is credited with rescuing from bankruptcy in the 1980s.

Team-building is a potent tool in all sorts of endeavors, from sports to business. It's also what drives successes in the healthcare industry, where not just dollars but people's well being and lives are at stake. Delivering affordable, quality healthcare to rural areas of a sprawling, sparsely populated state like Nebraska relies heavily on strong teamwork. It's the glue that bonds small, rural hospitals together into hospital networks that amplify those hospitals' ability to deliver quality healthcare under the critical access hospital program enacted by Congress in 1997.

That's how Colleen Chapp, regional services consultant at BryanLGH, a large regional hospital in Lincoln, Nebr., sees it. So does Mike Ellis, CEO at Community Medical Center, Inc., a small rural hospital at Falls City, Nebr., tucked into the southeast corner of the state. And it's how Al Klaasmeyer, administrator of Community Memorial Hospital at Syracuse, Nebr., sees it. His hospital, about 30 miles southeast of Lincoln, serves a rural population of 8,000 to 10,000.

They're in the business of team-building for high quality healthcare.

"I've never been a part of a group like this, where everyone has an equal say," says Ellis. "It's very professional and very cordial."

Networked Hospitals

Ellis' and Klassmeyer's hospitals are among 16 CAHs networked with BryanLGH, which serves as the network hospital. Chapp's role at the network hospital is to coordinate CAH efforts with hospitals in the network.

The CAH program requires each CAH in the state to be affiliated through written agreement with a regional hospital that serves as a network hospital. The 16 CAHs linked with BryanLGH as their network hospital are among Nebraska's nation-leading 58 CAHs, each affiliated with one or more of the regional hospitals that serve as network

hospitals in the state. The BryanLGH network is one of 11 such CAH networks across Nebraska. It is one of three CAH networks in the Heartland Health Alliance Critical Access Hospital Collaborative Network (to be referred to henceforth in this story as the CAH Collaborative Network).

Healthcare delivery efforts by CAHs and their network hospitals, in turn, are strengthened through teamwork with the Office of Rural Health in the state's Health and Human Services System (HHSS), the Nebraska Hospital Association, the Sunderbruch Corporation-Nebraska and other healthcare entities, say Chapp, Klaasmeyer and Ellis. For instance, the Office of Rural Health works hand-in-hand with CAH networks in channeling Federal Medicare Rural Hospital Flexibility Grant funds into a broad range of CAH programs throughout the state.

Collaborative Efforts

While the cost-based reimbursement that CAHs receive for Medicare and Medicaid patients may help keep those hospitals' doors open and allow upgrades in facilities and quality of healthcare, that's not the whole answer, Klaasmeyer and Ellis say. Strong collaborative efforts—team-building—among healthcare entities help make the CAH program work successfully.

The CAH hospital network is an instrument for that collaboration, these hospital administrators say. The network hospital linkup is a pathway to exchanges of information and grant-funded training and equipment their hospitals could not afford or attract on their own. It's training and education critical to providing high quality healthcare and continuing to improve on quality of healthcare for their patients.

Through those hospital networks, regional and CAH hospitals collaborate on everything from physician peer reviews and improving quality patient care to providing services that help CAH administrators' hone their skills for operating their hospitals more efficiently.

"I love the collaborative effort that we have in Nebraska," says Ellis, whose hospital serves a population of about 11,000, primarily in Richardson county, along with some patients from parts of western Missouri and northeastern Kansas. His hospital, for instance, enjoys the resources of the 23-hospital CAH Collaborative Network, which includes not only 19 CAHs and BryanLGH but also the following three regional hospitals: Mary Lanning at Hastings, Great Plains Medical Center in North Platte and Faith Regional Medical Services in Norfolk.

More Impact

Combining the needs of these hospitals in a network has more impact than a stand-alone hospital, he explains. "You put all of these small entities (CAHs) together, and they become big." A single grant for a small hospital might impact 10,000 people served by that hospital. But a grant for a group of hospitals in a network may impact 150,000 people, which makes a grant application to a state or federal agency more attractive, Ellis explains. It simply makes each grant dollar work harder, he believes.

"Working through the network in that manner has really helped us out. I am a very strong advocate of the critical access program and the impact it will have for rural America. It's really strengthened our hospital in the last 8 months (since it became a critical access hospital in January 2002). It's a tremendous program that people really need to understand—and need to understand its benefits," Ellis says.

Along similar lines, Klaasmeyer at the Community Memorial Hospital in Syracuse says, "There are a lot of things we can take advantage of because we are a CAH, and because we are in a network." Through the larger resources of the network, Klaasmeyer says, his hospital can draw on not only more kinds of training programs and services for physicians, nurses and other hospital staff but do so at lower cost than his hospital could purchase those services as a hospital operating solo.

Additionally, Klaasmeyer says, the staff at his hospital has the advantage of exchanging information, ideas and solutions to problems with other hospitals in the network. They can then draw on experience based on the large patient base among the network hospitals rather than just patients at the hospital in Syracuse.

"I think the network hospital is probably the key for a CAH," he continues. "That network hospital has certain responsibilities." Those responsibilities, he says, include resources "that we just couldn't get, if we were here by ourselves."

Under CAH regulations, a physician at a CAH is under no obligation to choose that CAH's network hospital when transferring a patient for care beyond what the CAH can provide. Rather, the physician can transfer patients to any qualified hospital.

What's the Benefit?

So, what's in it for a network hospital such as BryanLGH, when there's no guarantee that referrals from CAHs in the network will go to BryanLGH?

Without a second's hesitation, BryanLGH Hospital's Chapp answers: "Number one, it falls within our mission. We have a clear mission to provide patient-centered care in the state. As a collaborative network, we can implement larger healthcare projects to improve care for more patients."

Chapp works closely with administrators, physicians, directors of nursing, quality improvement coordinators and other staff at hospitals in the CAH Collaborative Network. The role she sees for BryanLGH as a network hospital is facilitating a number of strategic initiatives and evaluation of those initiatives that hospitals in the network have identified as important to achieving and maintaining high quality patient care.

She sees that role as a two-way street between the network hospital and other hospitals in the network. "Many rural hospitals have great suggestions that can be used in larger hospitals," she says.

The network hospitals don't choose willy-nilly where grant funds, staff time and other resources are to be directed for the purpose of improving healthcare among the network's member hospitals. Based on input gathered at regular meetings from healthcare professionals, administrators and other staff from member CAH hospitals, a network funding committee reviews needs among the network's hospitals and presents those findings to the total network membership, Chapp says.

Strategic Plan

Drawing on that input, administrators of CAHs in the network have developed a strategic plan which, among other things, identifies projects for which Flexibility Grant funds administered by the Office of Rural Health are sought. That strategic plan or workplan has been approved by the Office of Rural Health in HHSS.

The CAH Collaborative Network's plan has five strategic initiatives (listed in the accompanying box) and is called the Heartland Health Alliance Critical Access Hospital Workplan. Network member hospital CEOs meet every other month to review the status of this plan and progress in meeting its goals, according to Chapp. She sees the network hospital role in this process as that of a partner with other hospitals in the network.

Her job also includes coordinating quarterly meetings with the network hospitals, at which they focus on such clinical projects as pneumonia, congestive heart failure, stroke and pain management. Quarterly meetings always focus on quality improvement involving one or more clinical topics, Chapp says, to see how best practices have been implemented for everything from patient care to hospital administration.

A key goal of those quarterly meetings, Chapp says, is to develop a baseline assessment tool that allows measuring a year from now if efforts by hospitals in the network are making a difference in patient care. They do that by working together and by sharing information on how well best practices are being followed, how medical forms are being used, and how well myriad other standards are being met, including even those for housekeeping and laundry.

Some Examples

Following are examples of how Chapp and the CAHs work together under some of the strategic initiatives listed in the accompanying box:

- Assisting CAHs with collection and analysis of data that help identify which healthcare services attract patients to a CAH hospital and which services residents opt to find outside the community—and why they do. The Sunderbruch Corporation, a quality improvement organization, contracts with CMS (Centers for Medicare and Medicaid Services) to collect and analyze data for a CAH. Chapp facilitates a clinical team to review clinical data and identify actions a CAH can take. Those actions include guidance on how that CAH can inform the community about staff expertise, new equipment, services and classes the hospital offers. ("I think we've been very lax in letting the general public know what we're doing . . . so that people are aware of our services and how that might save them a trip into Lincoln or Omaha," says Klaasmeyer at Syracuse.)
- Saving the CAHs time and travel expense by bringing training for hospital staff to the CAHs. One example is the network's purchase of two computerized mannequins for CPR, advanced cardiac life support (ACLS) and basic life support training. These computerized mannequins, purchased by the network with Flexibility Grant funds, can be programmed to represent various patient conditions and then measure performance of healthcare givers' responses to those conditions. It's a way for physicians and nurses to receive training and certification of performance standards without them having to leave their CAH hospital.
- Providing educational programs to fulfill clinical and business compliance requirements of CAH

hospitals. The network uses grant funding in some cases to deliver education to healthcare professionals and administrators through audio conferences. Plans for the future include delivering that kind of education via the Internet and inter-active video. These are ways for CAH personnel to access education without having to leave their communities. In other situations, the educational function of programs through the CAH network may be on-site, where teams from BryanLGH go to CAHs to provide training and education for nursing staff so that they can work with their own equipment in their own environment in practice sessions, Chapp says.

- Working with local law enforcement, hospital, EMT and other community representatives involved in emergency protective custody issues. A mental health representative from the state might also be part of the group addressing this matter. "There's a real need out there to clarify this (who is responsible for what and who can make decisions)" Chapp says.
- Helping CAHs who are making the transition from a contract lab to an in-house lab. Flexibility Grant money made available to the network via the Office of Rural Health is available to provide a CAH with technical help in setting up staffing, equipment, quality control and policy and procedures for an in-house lab.

Those are examples of efforts in progress under the CAH Collaborative Network's strategic initiatives.

Chapp meets with CAH administrators and professionals regularly to review such matters as clinical outcomes, best practices and compliance with CAH regulations required under the CAH program.

"There is so much data out there," Chapp says. "One of the frustrations I've heard from CEOs and quality improvement leaders is, 'How can we make this data useful?' Through this (network) partnership we've been able to make that connection," Chapp says.

But that's merely a milestone, not the destination. "In the area of quality improvement, there is still more work to be done," Chapp says. "In the last year, we've been able to determine what we need to do. We all want to make sure everybody has access to resources to implement best practice standards. I firmly believe that's going to make a difference.

"It's important to recognize that the expectation through patients' eyes is to get high quality care wherever they go." A collaborative network is one way those expectations can be met, Chapp says.

"It's been great to have and recognize the many successes from the different hospitals," she says.

Heartland Health Alliance Critical Access Hospital Workplan's Five Strategic Initiatives

1. Develop strategies to enhance quality assurance and improvement and reduce outmigration of primary care and acute care services.
2. Conduct advanced cardiac life support and basic life support training.
3. Provide education programs to fulfill clinical, business or compliance needs.
4. Develop mechanisms for community collaboration to address local needs.
5. Develop a plan for a laboratory network, to include regional support for transition to in-house laboratory services.

A NEBRASKA Story

KEARNEY: Good Samaritan Hospital

BY DAVE HOWE

A prudent motorist doesn't head out on a long trip to a new destination without first consulting a reliable map and then checking route signs along the way.

So it is for Good Samaritan Hospital at Kearney, which is travelling with a dozen small, rural hospitals on a "journey" that spans 200 miles, as the crow flies, from near the Nebraska-South Dakota border in north central Nebraska to the south-western corner of the state.

But this "trip" isn't about driving from one destination to another. It's about delivering affordable, quality healthcare to rural communities scattered throughout the above-described region.

That takes a map. More precisely, a strategic plan.

"The biggest thing from our standpoint is our strategic plan," says Dave Glover, senior vice president of Good Samaritan Hospital at Kearney, Nebr. This regional hospital in central Nebraska is linked with 12 critical access hospitals—small rural hospitals—throughout the region in a hospital network under the Federal Critical Access Hospital (CAH) program enacted in 1997.

CAH HOSPITALS IN NETWORK

Brown County Hospital, Ainsworth
Gothenburg Memorial Hospital, Gothenburg
Callaway District Hospital, Callaway
Kearney County Community Hospital, Minden
Chase County Hospital, Imperial
Rock County Hospital, Bassett
Cozad Community Hospital, Cozad
Tri Valley Health, Cambridge
Dundy County Hospital, Benkelman
Webster County Community Hospital, Red Cloud
Franklin County Memorial Hospital, Franklin
Valley County Hospital, Ord

FOR FURTHER INFORMATION, CONTACT:

Dave Glover (308) 865-7900
Jerrell Gerdes (308) 425-6221
Michael Anaya (308) 423-2204
Dave Palm (402) 471-0146
John Roberts (402) 421-2356
Dennis Berens (402) 471-0142

Nine Goals

The network's plan includes nine goals and the strategies to achieve those goals for the benefit of healthcare consumers in the rural communities served by the 12 CAHs, Good Samaritan Hospital and four non-CAH hospitals at Holdrege, Lexington, Broken Bow and McCook.

The Good Samaritan CAH network is one of 11 such CAH networks in Nebraska, each consisting of one or more of the state's 58 CAHs attached through written agreement to a regional hospital serving as a "hub" or network hospital.

Under the CAH program, CAHs receive cost-based reimbursement for their Medicare patients and, under a Nebraska program, cost-based reimbursement for Medicaid patients.

That's the foundation upon which CAHs are building quality healthcare with the help of projects and services provided through the CAH hospital networks. CAH networks are doing that with the help of federal funding allocated to them by Nebraska's Office of Rural Health under the Federal Medicare Rural Hospital Flexibility Grant Program enacted in 1999.

Projects such as those in the Good Samaritan Hospital CAH network take a variety of forms. They include:

- Training and education of medical staff and administrators at CAHs.
- Information-sharing on problems and problem-solving among CAHs and other hospitals in the network.

- Physician peer reviews.
- Quality assurance improvement.
- Training for compliance with CAH rules and regulations.
- Communications, including such technologies as telemedicine and Internet delivery of training sessions.
- Coordinating and strengthening patient transfer procedures.

Many of the projects are affordable or available to small, rural CAHs through the strength-in-numbers of the CAH network. They are opportunities that CAHs can draw on to expand and improve healthcare services in their communities—opportunities that these CAHs couldn't afford or wouldn't have access to on their own.

The Region

The landscape within the region served by the Good Samaritan CAH network ranges from undulating Sandhill grasslands with ranches to irrigated Platte Valley corn and soybean fields as flat as a billiard table and just as green in the summer. But one feature most of the region holds in common is a sparse population with primarily an agricultural/retiree economy that poses challenges in terms of distance and fragile economic base for healthcare.

The 15-bed Franklin County Memorial Hospital in Franklin, Nebr., has four clinics, one in Franklin and three in surrounding towns. This hospital, one of the CAHs networked with Good Samaritan Hospital, serves about 5,000 residents along the Nebraska-Kansas border, and has an inpatient census that runs about 75% Medicare and 10% Medicaid, according to the hospital's administrator, Jerrell Gerdes.

Average daily patient census at Dundy County Hospital (DCH) at Benkelman, Nebr., is two, according to hospital CEO Michael Anaya. About 70% of the hospital's patients in this southwestern corner of the state are on Medicare, another 12% to 13% on Medicaid, according to Anaya. DCH, also networked with Good Samaritan Hospital in Kearney, is a 14-bed hospital that, along with its two rural clinics, serves about 4,500 residents in Dundy County and neighboring parts of Kansas and Colorado.

These hospitals and other CAHs provide emergency medical care locally, where greater time and distance to such care outside the community is potentially critical. And they save residents the time and cost of traveling outside the community for many on-going healthcare services, which is especially important to elderly residents who often find travel difficult.

Not Everyone's Savior

The CAH program "is not a savior for everyone," says Gerdes at Franklin. The cost-based reimbursement is some improvement over the old Medicare payment program for his hospital, he continues. But it isn't making as much difference for his hospital as it is for some CAHs, partly because of low population, building space and other factors, according to Gerdes. "It's given us our cost and cashflow, but we're not getting rich."

Without cost-based reimbursement, the county hospital and its four clinics at Franklin and three other towns would be a lot more dependent on property taxes, which is currently $100,000 a year, according to Gerdes. "If CAH hadn't come along, the county would have been faced with closing or being willing to supplement with at least another $100,000 a year."

21 Subject Areas

Gerdes sees the professional improvement opportunities and other services available to Franklin County Memorial Hospital through the CAH network as a valuable part of the CAH equation. He cites the telemedicine network as one example. Another is training and education programs through HealthStream, which the Good Samaritan Hospital network "negotiated at a very favorable price for all CAHs," he says. It offers training and education in 21 different subject areas for hospital employees ranging from physicians to cleaning staff, according to Gerdes. "We could have accessed it on our own, but by using it through the network it was quite a bit cheaper. And, we can do it all online," he adds.

Through telemedicine, medical staff at the hospital in Franklin have an opportunity to sit in on weekly telemedicine conferences that feature presenters from such institutions as the Mayo Clinic, Creighton University Medical Center and the University of Nebraska Medical Center.

This is an example of how Flexibility Grant funds are used in the hospital network to enhance rural healthcare. "We've had really good luck with the educational aspects (of the hospital network), and particularly quality assurance," Gerdes says.

Through the network, CAHs have access to software programs that let them do financial planning based on various cost assumptions. The Good Samaritan network also sets up procedures through which member CAHs can do credentialing and peer reviews.

Gerdes says peer review is especially valuable to his hospital at Franklin, which has a husband-wife physician team. Through the network, their charts are reviewed by physicians at CAH hospitals

in Imperial, Bassett and Callaway, he says. In turn, physicians at Franklin review charts from the hospitals at those towns. That avoids a competitive situation where doctors in nearby towns are reviewing each other's charts, Gerdes says.

Working through the hospital network is also important in data collection, Gerdes says. A small hospital has trouble developing meaningful data and criteria for making comparisons. Studies based on the larger data base of a group of hospitals in the network produce a better measure of quality assurance and a better indicator of what's being done right and what needs to be corrected, Gerdes says.

Out in the southwestern corner of the state, says Anaya, the 14-bed Dundy County Hospital in Benkelman and its clinics had sustained operating losses 7 straight years before converting to a CAH in December 2000. He credits conversion to CAH and "a lot of internal re-engineering and restructuring that lowered our overhead, plus staff working diligently in optimizing resources" for the hospital's climb into the black this past fiscal year.

Leader-to-Leader

"The CAH network and our ability to function has enhanced overall quality and outcome for our patients," Anaya says. One example of this hospital's relationship with the Good Samaritan Hospital network, he says, is a "Leader-to-Leader" shadowing program for OB/C-section nurses. They spend time at the network hospital, which has an OB/C-section workload that the nurses don't see day-to-day at Benkleman, Anaya explains.

DHC has taken advantage of the leader program through the network in other areas as well, including such operational areas as materials and purchasing management.

Anaya says he also finds help from Good Samaritan Hospital and the network in navigating through Medicare's some 130,000 pages of procedures and regulations by which his hospital and staff must abide.

"We are resource-sharing," Anaya says. "The CAH hub (Good Samaritan) is like a data warehouse or clearinghouse for other CAHs to share information and identify and leverage best practices." He says his hospital shares with other network CAH hospitals what works for it, and those hospitals share their ideas with his hospital.

Like Gerdes at Franklin, Anaya finds such network collaborative efforts as education and training of hospital staff through HealthStream to be valuable tool for DCH. "Good Samaritan picks up 75% of the cost; participating CAHs pick up the balance," Anaya says. "It has helped us assess strengths and weaknesses of our people. It's a wonderful educational tool."

Avoiding Isolationism

The CAH network helps small rural hospitals get past the "isolationism in rural areas" and feel comfortable in seeking outside help, this rural hospital administrator says. He likens the network hospital, which is familiar with rural hospital needs, to "a big brother or big sister" that wasn't available before conversion to a CAH. "We're all working together for one reason and that's to provide high quality care."

Glover at the network hospital says the network's strategic plan is the product of collaboration by CAHs in the network. "The biggest thing we've learned is that to be a good network hospital, you have to be able to gather information and ideas from CAH network hospitals and listen to what their needs are."

It's important to understand that the network is a partnership not only between the network hospital and the CAHs but also among the CAHs, he says. "Get to know each other," he counsels. "Be able to call with a problem." A lot of problems are shared among the hospitals, he adds. "That's the power of networking."

Network Activities

Hospital network activities include quarterly meetings for exchanges of information among administrators, nursing directors, quality improvement directors and other staff from the network hospital and CAHs in the network.

The hospital network sometimes arranges for educational programs to be presented via the telemedicine network, allowing staff members at CAHs to participate in education programs from their own hospitals. "That, I think, has worked out rather well," Glover says.

Through the private company HealthStream, educational programs on such topics as safety, infection control and patient confidentiality are provided via the Internet to medical staff at CAHs in the network, according to Glover.

In a recently initiated program for the network, Good Samaritan hospital has employed an "outreach nurse" whose responsibilities are to insure that patient referrals have gone well, Glover says. Her job is to answer questions from the patient and the patient's family and to insure continuing communications between the physician at Good Samaritan and the healthcare giver at the CAH.

In this outreach role, that nurse makes sure that, when the patient is discharged, all orders for medications and other written processes are complete and that care management such a wheelchair or other patient needs have been taken care of, to insure good continuity of care.

She prepared for her role as an outreach nurse by meeting with physicians, nurses and other personnel at Good Samaritan and with physicians, physician assistants, administrators and nursing staff at each of the CAHs so that they would know who she is, Glover says. And it's proven to be so popular that staff at Good Samaritan have started to refer patients to her who are not CAH referrals, Glover says.

Under the CAH law, a CAH has no obligation to send its patients to the network hospital when referring patients for care the CAH can't provide. "That (referrals) is not the issue," Glover says. Rather, rural healthcare is.

"Here in rural Nebraska, with distances and changes in population, anything we can do to help support our rural partners is important," Glover says. The network strategic plan's vision statement says, in part: "The CAH network will utilize a collaborative approach to improving processes for communication, quality assurance, peer review and credentialing, so that care is optimized within each hospital in the network, as well as when patients are transferred from CAHs to the tertiary care hospital."

"An area of emphasis in our strategic plan is our commitment to strengthening and supporting rural health care. We (Good Samaritan Hospital) see the CAHs and network program as a way to strengthen and help keep those CAHs viable and financially strong," Glover says. "The foundations of rural health are rural hospitals and we need to keep those rural hospitals open and strong, so that they can be there when they (patients) need them."

Good Samaritan Hospital
Critical Access Hospital Network
Strategic Plan Goals

1. Review transfers within the network to ensure that the process is efficient and that information is as complete as possible with each transfer.
2. Continue utilizing and improving the peer review process that was implemented throughout the network.
3. Continue the credentialing review process for those network hospitals that have requested hub hospital oversight.
4. Indentify areas of focus for network hospitals and develop quality goals for the network that meet their needs.
5. Explore the compliance resource needs of the individual network hospitals.
6. Design a comprehensive leadership development plan that includes medical staff, board of directors and senior management of each of the network hospitals.
7. Continue the use of the HealthStream Educational System.
8. Review communication processes among the network hospitals to ensure that timely and complete information is being shared with regard to patient care.
9. Work with all critical access hospitals to meet requirements, and develop processes needed.